Minority Women

OFFICE OF MINORITY HEALTH
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1-800-444-6472

Dimensions in Health

Final Report

June 18-20, 1992

Sponsored by

U.S. Public Health Service, Region VIII

Office on Women's Health

PHS Coordinating Committee on Women's Health Issues

Office of Minority Health

MH93D1811

I AM PLEASED TO PROVIDE YOU

WITH THE ATTACHED MATERIAL

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Minority Women: Dimensions in Health

Final Report

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Compiled and edited by

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U.S. Public Health Service, Region VIII

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This document is a report of the conference "Minority Women: Dimensions in Health." It is a compilation of the statements of conference participants. The opinions expressed herein do not necessarily represent the official views of the sponsoring agencies.

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Excerpts from this work may be reprinted if proper credit is given.

A special thank you is extended to Aileen Duran, Secretary to the Region VIII administrator of the Administration for Children and Families, who did the art work which appears on the cover. Her donation of both her time and talent is especially appreciated.

Background papers for each track were prepared for the use of conference participants by Nancy Thomann, M.P.H., Minority Health Coordinator for Region VIII, U.S. Public Health Service.

Minority Women Dimensions in Health

Special Role of the Office on Women's Health

In the mid-1980's, the Public Health Service established a PHS Coordinating Committee on Women's Health to provide a mechanism to define and coordinate women's health issues. In 1990, the Office on Women's Health was established in the immediate office of Dr. James Mason, Assistant Secretary for Health. Dr. Agnes Donahue was appointed the first director of that office. The interest and support of the Congressional Caucus on Women's Health has given impetus to the work of the Office on Women's Health. In September, 1991, the first comprehensive PHS Action Plan for Women's Health was presented to the Caucus leadership. This report, along with the Healthy People 2000 Report, forms the basis for establishing national and regional health objectives to improve the health and well-being of women.

Dr. Agnes Donahue was the inspiration for this Region VIII Minority Women's Health Forum. She and the former Region VIII Health Administrator, Dr. Audrey Nora, identified the need for a meeting which would allow state and local women to develop an agenda for change, including state action plans. From Region VIII of the Public Health Service, Charlotte Gish (Regional Reproductive Health Consultant), Nancy Thomann (Regional Minority Health/FDA Coordinator), and Jane Wilson (Regional Minority Health/AIDS Coordinator) began the process of planning and implementing the conference. Dr. Donahue met with the Regional Conference Planning Committee to develop a vision of this meeting, and continued to provide leadership, vision, and resources so that this meeting could occur.

Planning Committee Acknowledgments

A special thank you is in order for those persons on the Minority Women's Health Conference Planning Committee. Their input and advice was invaluable in forming the structure for this conference. Their participation on this committee displays their interest in and commitment to improvement of the health of minority women in our region.

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The following people served as facilitators for the workgroups during the conference. The U.S. Public Health Service wishes to acknowledge their willingness to assume the important responsibility of helping conference participants discuss the issues and arrive at recommendations.

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Supporting Agencies

The following individuals and/or agencies have supported the Minority Women's Forum by providing written materials, information, documents or data that have been provided to conference participants or used in the preparation of the background papers.

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American Cancer Society

National Urban League

American Heart Association

Arthritis Foundation
Rocky Mountain Chapter

Older Women's League

Healthy Mothers—Health Babies

Robert Wood Johnson Foundation

Colorado Domestic Violence Coalition

State Health Departments of Colorado, Montana, North Dakota, South Dakota, Utah and Wyoming

Special Contributors

Special thanks are given to the following org ons who sponsored various activities within the conference schedule. Each of these org has demonstrated a strong concern for health issues surrounding the American r woman.

American Association of Retired Persons

The reception on Friday evening was hosted by AARP Minority Affairs Initiative, which aims to improve the economic, social and physical well-being of the nation's older minorities by addressing issues that directly affect their quality of life. The Associate Area Representative for AARP, Area 8 Office, is Kirsten Ball, Salt Lake City, Utah.

Gynopharma

The morning refreshments were sponsored by Gynopharma. They are headquartered in Somerville, New Jersey, and are devoted exclusively to women's healthcare. The company markets ParaGard® T380A (Intrauterine Copper Contraceptive), the only copper IUD available in the United States, and is committed to research and development of contraceptive and gynecological products.

Wyeth-Ayerst Laboratories

Wyeth-Ayerst contributions made the afternoon break refreshments possible. Wyeth-Ayerst Laboratories are noted for world-wide leadership in female healthcare.

Conference Agenda

Minority Women—Dimensions in Health

Sponsored by U.S. Public Health Service

Thursday, June 18

5:00–8:00 PM Registration

Friday, June 19

7:30 AM Registration

8:30 AM **Opening Ceremonies**
Welcome: Hugh S. Sloan, D.S.W.
Acting Regional Health Administrator

Jane Artist, Regional Director
DHHS

Audrey H. Nora, M.D., M.P.H.
Assistant Surgeon General and Acting Director
MCH Bureau, HRSA

A Call to Conference
"Future of Women's Health in the Public Health Service"
James Mason, M.D., Dr.P.H.
Assistant Secretary for Health
U.S. Public Health Service

"Minority Women's Health"
Marilyn H. Gaston, M.D.
Assistant Surgeon General and Director
Bureau of Health Care Delivery and Assistance
HRSA, USPHS

Charge to the Participants
National Perspective: Agnes Donahue, D.D.S., M.Sc.D., M.P.H.
Director, Office on Women's Health
U.S. Public Health Service

Conference Goals: Jane Wilson
Region VIII
U.S. Public Health Service

10:00 AM	Break	
10:15 AM	**Health Track Plenary** Moderator: Nancy Thomann, Region VIII	
		Panelists
	Track 1: Mental Health	Sumiko T. Hennessy, Ph.D. Executive Director Asian Pacific Development Center Denver, Colorado
	Track 2: Substance Abuse	Irene Aguilar, M.D. Westside Neighborhood Health Center Denver, Colorado
	Track 3: Violence	Jacqui Cunningham, L.C.S.W. Children's Hospital Denver, Colorado
	Track 4: Reproductive Health	Margueritte White, M.D. Assistant Professor Department of OB-GYN University of Colorado Health Sciences Center Denver, Colorado
	Track 5: Chronic Disease	Silvia Corral, M.D., M.P.H. Medical Director Salt Lake Community Health Center Salt Lake City, Utah
11:15 AM	**Focus Group Session I** *Each of the five tracks divided into three focus group sessions: (1) racial and ethnic influences, (2) women's life cycle; (3) interagency linkages/systems challenges. Each focus group identified a recorder. Participants selected a problem and identified interventions for that problem.*	
12:50 PM	**Working Lunch** *Lunch was served in each of the 15 focus groups. Participants continued their discussions and moved to the second assignment when ready.*	
1:45 PM	**Focus Group Session II** *Working groups identified barriers to the interventions developed in the first session.*	
3:45 PM	Break	

4:15 PM **State Meetings**

The states met to share information and began development of a state-by-state action plan for implementation when they returned home. Each state meeting chose a facilitator and a recorder. Each state reported their action plans on Saturday afternoon.

6:00 PM **Reception**

Saturday, June 20

7:30 AM Continental Breakfast

8:30 AM Announcements
Jane Wilson, Region VIII

8:45 AM **Plenary Session**
Moderator, Charlotte Gish, Region VIII

"How to Change and Develop Public Policy"
Catherine M. Crawford, Ph.D.
Graduate School of Public Affairs
University of Colorado

Reactor Panel
Marguerite Salazar, M.A.
Executive Director
Valley-Wide Health Services
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Cecelia Firethunder
Health Planner
Community Wellness Trainer
Oglala-Sioux, South Dakota

Rev. Marjorie Lewis, Ph.D.
Assistant Professor
Graduate School of Public Affairs
University of Colorado

9:45 AM Break

10:00 AM	**Health Track Session** *In each of the five tracks, recommendations were suggested for changes in policy or procedures at the local, state, and federal levels which would make it possible to remove barriers to implementing interventions.*
12:00 PM	**Working Lunch** *Lunch included presentations from each of the Health Track Sessions.*
2:00 PM	**State Meetings** *States submitted action plans for activities which they proposed to initiate within the next year. Federal participants met independently.*
3:00 PM	**Closing Ceremonies** *States presented their reports.*
	Summary and Conference Adjournment

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Mental Health & Minority Women

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Reproductive Health & Minority Women

Chronic Disease & Minority Women

The Policy Process

State Recommendations

Appendix

Opening Ceremonies

1

Participants were welcomed to the conference by Hugh S. Sloan, D.S.W., Acting Regional Health Administrator, and by Jane Artist, Regional Director of the Department of Health and Human Services.

Opening Remarks

Audrey H. Nora, M.D., M.P.H.
Assistant Surgeon General and Acting Director
Maternal and Child Health Bureau
Health Resources and Services Administration

I am very pleased that I was able to return to Denver for this conference, which I see as addressing a great need in our region. Dr. Agnes Donahue and I first discussed the idea for such a conference a number of months ago, and we both agreed that when we looked at the numbers for infant mortality and teen pregnancy, and the significant differences in the morbidity and mortality rates for minority people, we needed to address the specific needs of this population. I would like to thank the Office on Women's Health and the Office of Minority Health for their willingness to provide the support for our regional office to put on this conference. I wish each of you success as you meet to discuss the problems and develop your recommendations for addressing them.

(Dr. Nora then introduced Dr. James Mason, M.D., Dr.P.H., the Assistant Secretary for Health of the Department of Health and Human Services.)

Attached is the text prepared for delivery; however, some material may have been added or omitted at the time of delivery.

Call to Conference

James O. Mason, M.D., Dr.P.H.
Assistant Secretary for Health
U.S. Department of Health and Human Services

I'm pleased to have this opportunity because one of the duties I chose as Assistant Secretary for Health is to serve as Co-Chair of the PHS Coordinating Committee on Women's Health Issues. And I'm gratified to see that action on this important issue has moved beyond the Washington beltway.

As I look out, you personify the hope of a shared vision—the vision of advancing the health of women across the spectrum of life. And I congratulate you on the selection of minority women's health for the focus of this conference, because it is here, within this population, that we can make some of our greatest advances. The percent of mothers who receive early prenatal care provides us an example of the disparities that exist.

Our nation has a disgraceful infant mortality rate. We rank 22nd among industrialized nations in the number of babies that die before they reach their first birthday. Even though we have improved on our overall infant mortality rate, we have not been able to narrow the gap between babies born to White women and those born to women of color. And we haven't made a dent in the low birth weight rates since 1970. One of the most important things we can do is provide early comprehensive prenatal care to the mothers of our children.

In 1988, only 58 percent of American Indian and Mexican-American mothers received early prenatal care. Similarly, only 61 percent of Black mothers and 63 percent of Puerto Rican and Central and South American mothers received early care. The proportion of mothers with early prenatal care was much higher among Japanese-American mothers at 86 percent, followed by Cuban-American mothers at 83 percent and Chinese-American mothers at 82 percent. Seventy-nine percent of White mothers received early prenatal care.

One has to question why such disparities persist. The English philosopher Lord Herbert said, "The shortest answer is doing." One of the Department of Health and Human Services' priorities is doing something about disparities. And like that Energizer Bunny, we're going to keep going and going and going until it is done.

One of our nation's health objectives for the year 2000 is increasing to at least 90 percent the proportion of all pregnant women who receive prenatal care in the first trimester of pregnancy. This objective is one of 300 health promotion and disease prevention objectives contained in the document *Healthy People 2000.* But I believe this objective is also one of the most important. If we expect to remain a leader of nations, we must invest early on in our children's development.

In September 1990, The Department of Health and Human Services released *Healthy People 2000.* It's a national strategy for improving the health of American men, women and children over the coming decade. It sets forth three overarching goals:

- Increase the span of healthy life for all Americans;
- Reduce health disparities among Americans; and
- Achieve access to preventive services for all Americans.

To accomplish all this, the nation set 300 measurable, achievable objectives grouped together under 22 priority areas. Thirteen of those 22 priority areas contain objectives that directly address women. However, the widely disparate health needs of women demand more attention and scrutiny.

The Public Health Service has gone the extra mile. It is the first to recognize—and act on—the specific health needs of women. On July 17, 1991, the Public Health Service established an Office on Women's Health. The Director of that Office, Dr. Agnes Donahue, will be speaking to you later this morning. She serves as my eyes and ears in the world of women's health. She reports directly to me, and I assure you she makes it her business to make women's health my business.

Under Dr. Donahue's capable leadership, the Office on Women's Health released a *PHS Action Plan for Women's Health* in September 1991. It's a blueprint for advancing the health of women across the spectrum of life. I want you to focus your attention on that plan. A copy is in your information packet.

The PHS *Action Plan for Women's Health* takes a comprehensive, nationwide assessment of the priority health concerns confronting women. It directs attention and resources toward women's needs in prevention, research, education and services. The plan commits Public Health Service agencies and program offices to specific steps and goals addressing these needs. And it complements and strengthens our nation's *Healthy People 2000* efforts.

Let me just get into several areas that we are giving particular attention to. This summer the National Institutes for Health and the Alcohol, Drug Abuse and Mental Health Administration expect to release national agendas for women's health research. These agendas will advise the scientific community on the top priorities in research needs for women. This fall, the Food and Drug Administration will release a report on how it tests new drugs to assure they are safe and effective for women. Also this fall, NIH will release the first date showing whether scientists are following guidelines to include women in relevant clinical research trials.

And finally, there is the Women's Health Initiative; it's the largest study ever on health issues of interest to women. It is scheduled to begin in the fall and will be conducted over the next 10 years and involves the recruitment of 65,000 women participants. Research areas include breast cancer, cervical cancer, menopause, heart disease and osteoporosis. And a community-based component is on the drawing board. The era of research being done on men, to the benefit of men only, is over.

Another example under *Healthy People 2000* and the *PHS Action Plan for Women's Health* is Healthy Start. This project concentrates efforts and resources on 15 communities with some of the highest infant mortality rates in the nation.

Healthy Start is not just a medical model. We already know that access to prenatal and clinical services for pregnant women is absolutely the foundation to lowering infant mortality. We know there are proven ways to bring women into services. We know there are ways to meet their special needs. We know what works. We also know that good medicine and good doctors are not enough. Encompassed and wrapped up in Healthy Start is not only access—the foundation of medical services—but also outreach, service integration, community involvement and personal responsibility.

Access means that care is available when and where people need it. This means that providers are trained to recognize and respond

to the problems of women—and facilities are designed to meet their needs. It means that systems are in place to provide comprehensive primary care, prenatal care, alcohol, drug abuse and mental health treatment, and HIV/AIDS services to high-risk women and their families.

Outreach means reaching out to women and bringing them into care. In these epidemics of HIV infection, alcohol and other substance abuse, we can no longer wait for women to come to us. The ones who need help the most may never come. We have to go to them. We have to go where hard-to-reach, high-risk women live, work, and socialize. We have to speak their language—respect their cultures—and lead them into care.

Services integration means coordinating and linking community health centers, Medicaid eligibility, nutrition services such as WIC, prenatal care, family planning, and well-baby care together. Women are more likely to seek primary care for health problems or injuries than they are to seek treatment for addiction or mental health problems. And because they will seek treatment for the physical symptoms of substance abuse without admitting to substance abuse, services coordination is essential.

It's like the story about the kindergarten class that visited the local police station and saw the photos of the 10 most wanted men. One child pointed to a picture and asked if it was really the picture of the person. "Yes," replied a policeman. "Well, why didn't you keep him when you took his picture?" demanded the youngster.

When a woman comes in for care, whether it's for prenatal care, alcohol dependency, or her kids' immunizations, we need to keep her. It may be our only chance to see and care for that woman. Does she appear to be abused? Does she need to have a mammogram? Does she have symptoms of HIV or AIDS? Is she depressed?

To do this we need especially aware providers. Ideally, the primary care provider and the substance abuse treatment provider should be one-and-the-same. When that's not possible, the primary care provider must be able to detect chemical dependency and direct the woman in for treatment and vice versa.

Women in alcohol and other substance abuse programs often desperately need primary care for gynecological problems, cancers, infections, and other illnesses. The substance abuse treatment provider must be able to recognize these problems and see that women get appropriate services.

Services integration also means making services "user friendly"—designing services for women with their unique needs in mind. It means making services convenient, simple, and understandable. It means removing red tape and barriers—adopting flexible service hours—providing transportation for women and their children—and implementing "one-stop-shopping" or a "supermarket of services" —getting all the services together in one location.

Community involvement is a key principle. It starts with the realization that the present state of affairs is no longer acceptable. It means communities must pull together to solve the deeply entrenched, often interrelated problems of substance abuse, mental health, violence, reproductive health and chronic diseases. Because each community has unique resources that can help reach high-risk women, it means a team which brings together local and state governments, tribal councils, the private sector, schools, churches, and other civic and social organizations.

The final principle is personal responsibility. The truth be known, two-thirds of all premature deaths and disabilities in this country are the result of people making poor

choices for themselves. The limits of what health professionals can do are painfully clear. Personal responsibility means that we must inspire women to take charge of their health and well-being. In short, we need to create what Secretary Sullivan refers to as a "culture of character." We must help give women the *hope* that leads to a sense of future.

Together the five principles—access, outreach, service integration, community involvement and personal responsibility—are the essential pieces advancing the health of women across the spectrum of like. If we can't deliver all of that, if we just try to deliver one of those components, we're not going to realize our Healthy Start goal, our 300 *Healthy People 2000* objectives or our vision of advancing women's health.

Putting those five basic dynamic principles into practice is the challenge. It's the challenge for the U.S. Public Health Service. It's the challenge for states, communities and individuals.

I challenge you to put those five principles together. Put them together in the way that makes sense and works best in your community. Involve at-risk women in the planning. Let them buy in. Empower them. If you really want to succeed, hire and promote them. We need more women in leadership positions in our clinics and treatment centers and in our communities. I'm proud to be surrounded by women in high leadership positions.

The wealth of local, state and federal talent drawn to this conference was gathered for a purpose. Our combined resources and talents can successfully address the challenge at hand. *The PHS Action Plan for Women's Health* is a model for what you can achieve. I want you to use it and refer to it as you develop your own plans for action on the issues of mental health, substance abuse, violence, reproductive health and chronic disease. We are making progress in these areas but we need to do more.

Your work will provide direction for minority women's health in Region 8. Your voice, your recommendations will help the nation realize its health goals. It's written that "Men," and I'll add women, "of action intervene only when the orators have finished." I'm finished. The year 2000 is coming. And we have lots of work to do.

Highlights of Plenary Presentation

Marilyn H. Gaston, M.D.
Assistant Surgeon General
Director, Bureau of Health Care Delivery and Assistance
Health Resources and Services Administration
U.S. Public Health Service

Dr. Marilyn Gaston presented numerous slides which illustrated the many disparities in the health status of women of color when compared with that of white women. Dr. Gaston pointed out the risk factors which lead to poor health in minority women. These risk factors include

1. obesity which is common among minority women and which leads to other health problems such as diabetes and hypertension;
2. hypertension which is common in Black, Hispanic and Native American women and is a risk factor for heart and other cardiovascular diseases;
3. socioeconomic factors such as poverty, uninsurance, lower educational and occupational levels, etc.;
4. societal attitudes toward minority women leading to poor self esteem, depression and a mistrust of the health care system;
5. the use and abuse of such substances as alcohol, drugs and tobacco which increase risks for heart disease, cancers, and poor pregnancy outcomes; and
6. poor nutritional habits which adversely affect health status.

Dr. Gaston then discussed the various health care disorders for which minority women have increased incidence and prevalence rates or for which they have poorer outcomes, such as higher death rates or lower survival rates. She discussed disparities in infant mortality rates and the decreased early prenatal care among minority women, and looked at the utilization of prenatal care by method of payment. She noted the differing death rates for heart disease, breast, cervical and lung cancer, diabetes, and HIV infection.

Dr. Gaston pointed out that we do not have a clear understanding of why these disparities exist—research has been almost non-existent on women's health, and minority women's health in particular. We can only assume that the poorer health status results from socioeconomic and cultural factors which affect women of color to a greater degree than white women, and it is these factors that we must begin to address in order to see improved quality of life for minority women.

Charge to the Participants

Agnes Donahue, D.D.S., M.Sc.D., M.P.H.
Director, Office on Women's Health
U.S. Public Health Service

GENERAL OVERVIEW: Women's health is at a crossroads. The good news is that women are living longer, but the bad news is that they are sicker.

Many conditions that plague women and lead to excess morbidities are preventable—heart disease, some forms of cancer (especially lung cancer), sexually transmitted diseases, abuse of alcohol and other substances, and smoking-related illnesses.

Female life expectancy for white women is about 75 years. We all know that a lot of women—particularly minority women—don't live to see these advanced years. Yet their premature deaths, in so many cases, could be prevented. Minority women are dying in their 60's, 50's, and sometimes even in their 40's, with the long-term effects of high blood pressure and obesity, diabetes and other chronic disease. And now they are dying in their 30's and 20's with AIDS and complications of substance abuse. We can do something about this. Women of color have to know that they can (and must) be full partners in improving their health and reducing these rates of premature death.

The health of minority women is even further complicated by the unacceptable disparities in health indicators. Marilyn Gaston has laid out many of these health indicators. The plenary speakers with further define the issues in each track. Here are some points that are glaringly clear.

MENTAL HEALTH: One in every five women will suffer some type of clinical mental disorder at some time. Depression is a problem that plagues too many women. Minority women are quite vulnerable to this despair that saps the sense of well-being. The complex problems of lowered self-esteem are all too often a factor in unhealthy choices and behaviors.

SUBSTANCE ABUSE: Inappropriate use, dependence on, and abuse of alcohol and other drugs by women is rising and we have evidence that conventional models for treating these addictions are not as effective for women. Furthermore, cultural factors and family influences complicate the treatment outcome. Increases in smoking among women have led to the sharp rise in lung cancer. Fifty-six thousand women die of lung cancer each year. Lung cancer and other lung diseases are the leading cause of cancer death, surpassing even breast cancer. Although death rates from lung cancer are slightly higher among white women, minority women cannot rest easy here—the rate of lung cancer among black women is only a fraction below that of white women—and more and more minority women are smoking, particularly young women.

VIOLENCE: Violence against women, intentional injuries, spouse abuse, rape, abuse of female children, and yes, even homicide, are increasing *in all categories*. This is a national dilemma. Some groups of minority women suffer disproportionally higher rates of violence. Violence in communities affects women, men, and children—the entire family. Here again, minority families are

disproportionally affected. Violence is claiming the lives and maiming the bodies and souls of far too many of our young people. We have to work harder to turn this trend around.

REPRODUCTIVE HEALTH: We define the scope of women's health as that period from the onset of **menarche** throughout life. Yet many women know little about the menstrual cycle that marks the beginning and the end of their reproductive life. Sexually transmitted diseases are taking their toll on women's reproductive health. Eight million women are infected with sexually transmitted diseases every year. More than 750,000 cases of Pelvic Inflammatory Disease are diagnosed yearly. STDs account for 125,000 cases of tubal infertility, and nearly 50,000 ectopic pregnancies each year. Yet STDs are preventable illnesses. We've got work to do.

HIV infection, the cause of AIDS, is a sexually transmitted disease that now disproportionately affects minority women and their children. Women are the fastest growing group of persons with AIDS. Ten years ago AIDS was not listed as a cause of death among women. Yet in 1991, it was the fifth leading cause of death among women 25-44 years of age.

Leading Causes of Death

Black Women	*Rate/100,000*	*White Women*	*Rate/100,000*
Heart Disease	181.0	Heart Disease	114.0
Cancers (all)	131.0	Cancer (All)	110.0
Stroke	46.0	Stroke	25.5
Breast cancer	27.0	Cancer–lung	24.8
Cancer–lung	24.6	Breast cancer	23.0

CHRONIC DISEASES: In 1988, 380,000 women died of heart disease—almost the same number as men, yet many women don't even know they are at risk. Black women suffer even higher rates of heart disease than white women on an age-adjusted basis.

STROKE: This ranks right up there at the top of the list. Many groups of minority women have higher death rates from strokes. Black women suffer from stroke almost twice the rate of white women.

BREAST CANCER: There are 150,000 cases diagnosed each year. Breast cancer is the leading cause of cancer death among black women. But lung cancer is catching up fast. The marked rise in lung cancer among women is the result of increased smoking by women. Smoking among women has increased 100 percent in the past three decades, and women's lung cancer rates are increasing right along with it. We can definitely do something about this.

We have before us serious challenges in women's health. These challenges are complicated by shrinking resources. At the federal level we have developed a plan for action—the *PHS Action Plan for Women's Health*, and we have set an ambitious course towards improving the health of women. But federal government alone cannot make the differences in the lives of women, the lives of the minority women in your states, cities, towns, and communities. You are the ones who must make that difference.

Charge

The general charge to this conference is self-defining. You must develop, as a central objective of this conference,

> *State by state plans for action around health needs of minority women that you can take back and work toward in your states.*

Within each subject area track, you will be working in one of three focus groups: 1) Racial or Ethnic Influences, 2) Women's Life Cycle, or 3) Interagency Linkages/Systems Challenges. You will be asked to accomplish three things:

- Further define problems around the health needs of minority women in each state;
- Propose solutions for those problems that can be implemented at the state, local, and community level within the context of the needs of the population and the resources available;
- Identify barriers to implementation of your solutions and develop recommendations for change which will allow implementation of your plans.

After this conference is over, I challenge you to return to your states with a renewed commitment to advance the health of minority women. We have a lot of work to do in this meeting. The minority women of your states are depending on us.

Opening Ceremonies

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Substance Abuse & Minority Women

Violence & Minority Women

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Appendix

Mental Health & Minority Women

2

Background Paper

"I was able to recognize that her depression was in some part linked to an ethnic and cultural deprivation she experienced living in the U.S."

from "Ethnic and Cultural Diversity in Feminist Therapy: Keys to Power" by Julia A. Boyd (1)

- It is estimated that 23 million adults in the United States are severely incapacitated from mental disorders, not including substance abuse. Some 30,000 Americans each year take their own lives, and 5,000 of these are under age 25. (2)
- Suicide is the eighth leading cause of death in the United States and is associated with depression, schizophrenia, panic disorder, stress reactions, alcohol and drug abuse, and antisocial personality disorder. (2)
- Women are twice as likely to suffer from depression as men and are at higher risk due to social, economic, biological and emotional factors. There are at least seven million women in the U.S. with a diagnosable depression and most will go untreated, although 80-90 percent of patients can have symptoms reduced through treatment. (3) Depression is the leading diagnosis of mental disorder in women. Other disorders include schizophrenic disorders, which are up to six times more common in lower socioeconomic groups, but equally common in males and females. (4) Women are more susceptible to eating disorders and anxiety disorders. And primary degenerative dementia (including Alzheimer's disease), which affects older persons, is more serious for women because they live longer than men. (4)
- Risk factors for depression include unhappy marriages, poverty, maternal stress (the more children, the more depression), reproductive events (onset of menstruation, childbirth, menopause), personality, family roles and intimate relationships, work roles or lack of work, spouse absence, social isolation, victimization (particularly sexual and physical abuse), and health problems. (3)

- Women's roles as caring, supporting, helping, and understanding people who provide nurturance and emotional support to others and who are passively accepting add to their risk for mental disorders such as depression. (3) Posttraumatic responses to childhood sexual or physical abuse or to marital/acquaintance rape, battering, or sexual harassment are significant risk factors for women. (3)

Minority Women

- Minority women are affected to a great degree by depression, and it is aggravated by such factors as racism, lower educational and income levels, low-status/high-stress employment, immigration and acculturation, larger family sizes, marital dissolution, single parenthood, and poor health. (3) Misdiagnosis of mental disorders is a major concern among minority groups in general. (3)

—African-American Women

- The family patterns which influenced Africans were significantly changed by slavery, and new patterns developed which emphasized blood ties and the extended family. Black women have been viewed as the backbone of the family and not always economically dependent upon the male. The rate of divorce among Blacks is twice that of Whites, and Black women take in relatives at twice the rate of White women during the middle-age period. (5)
- Black women are at increased risk for stress, alcoholism, drug abuse and suicide. Affective nonpsychotic disorders are the most frequent mental diagnoses for Black women, followed by anxiety disorders. Most frequent complaints are depression and family problems. The rate of depression diagnosis among Black women using outpatient psychiatric services is 42 percent higher than that of White women. (3)
- Their female status, lower social class, and downward social mobility lead to even greater depression among Black women.(3)
- The quadruple stressor of being "old, poor, Black and female" increases the elderly Black female's inability to cope with the stress of aging. The loss of traditional network supports and the loss of family by death, disease or relocation of children are risk factors for the older Black woman. (6)

—Hispanic Women

- The Hispanic culture has a very strong, extended family orientation which may include close friends and children's godparents. The "machismo" of the Hispanic male, referring to head of household, breadwinner and protector, requires total obedience by spouse and children. The female's "marianismo" is therefore the traditional self-sacrificing mother and wife. (5)
- Hispanic women are overrepresented among lower socioeconomic classes and younger ages. One in seven Hispanic women over the age of 15 years was separated or divorced in 1981, and more than one out of two had no husband present. (3)
- Social alienation may lead to personal depression in Mexican-American women, and they may become overly involved with their children in order to cope with an inability to obtain self-gratification. Migration and culture shock lead to anxiety, and traditional cultural expectations may lead to depression. (3)
- The stresses of disintegration of family values, poverty, discrimination and the pressures of acculturation may lead to feelings of powerlessness, low self-esteem, loss of identity and depression. (3)
- Access to mental health services is a major issue for Hispanic women and may be related to their marital status. (3)
- Elderly Hispanic women are the least educated group of the aged with a median 7.4 school years compared to 12.1 for non-Hispanic Whites. There is a high rate of activity limitation from chronic conditions and higher rates of disability among those who are institutionalized, leading to depression. Language barriers, prejudice, and neglect by the formalized health care system, when added to poverty and a lack of health insurance, decrease the likelihood of elderly Hispanic women having access to mental health services. (6)

—Native American Women

- Again, the extended family is the norm for the Native American, and it is common across all the diverse tribes. Poverty, alcoholism, conflicts over acculturation and despair, poorer physical health and mental health status, and few resources to which to turn place greater stress on the Native American woman. (5)

- The welfare culture and stigma of poverty affect self-esteem for the Indian woman, and the impacts of cultural change and racism lead to self-neglect and self-destructive behavior. Lack of childhood nurturance leads to depression and violence in older children and adults, and child sexual abuse, physical abuse, neglect and family dysfunction are prevalent in Indian communities. (7) A new disorder is flourishing among women known as "cutters," who cut their arms, legs or other parts of the body to gain a sense of control through the bleeding. (7)
- Suicide among Native American women is twice as high as among the general population. They are at risk for depression due to poverty, lack of education, larger numbers of children, and poor families headed by single women. Female high school students in tribal-operated boarding schools are more prone to depression and phobic reactions than their male counterparts. Problem categories presented by Native American women seeking mental health services were (in order) alcohol misuse in family, adult-child relationships, grief reactions, child management and abuse and marital conflict. (3)
- Native American women with depression have two major problems: a significant number have experienced incest, rape and sexual assault; and many are at risk of self-medicating with alcohol and/or drugs. (3)
- Seventy-three percent of elderly Native Americans are estimated to be mildly to totally impaired relative to daily living. Many refuse to utilize social, economic or psychological resources available to them. (6)

—Asian/Pacific Island Women

- Immigration restrictions as to who in the Asian family might enter the U.S. have influenced family patterns and acculturation. By tradition, all relationships in the Asian/Pacific Islander family have been of the superordinate-subordinate type: husband/wife; parent/child; or teacher/pupil. Each person has a specific role in the family and in society. Newly arrived families must cope with the more equal roles of men and women and older and younger family members and the more assertive roles afforded women and younger people in the U.S. This can create family conflicts. (5)
- Although many Asian Americans have high educational levels, in 1980 one-half of Vietnamese women, one-fourth of Chinese women and one-fifth of Guamian, Filipino, Samoan and

Korean women had eight or fewer years of education. (3) Asian women are held up as models of docility and subservience; they are also stereotyped as both erotic and sexless. (3)

- Chinese women are inclined to handle their problems by being agreeable and accepting, and will blame their race rather than the American system for many of their difficulties. Low self-esteem is common, and there is a greater tendency toward depression among Chinese women than Chinese men. (3)
- Among Southeast Asian refugees, depression and posttraumatic stress disorder are common. Many of these females may have been sexually abused; however, they are reluctant to talk about rape during diagnosis and treatment. (3)
- Older Asian women have extremely high suicide rates. At age 45, the rate for Chinese women begins to rise, and the rate for Japanese women 75 years and older is higher than that of White women the same age. The reasons for these higher rates are pretty much unknown. (8)
- Asian Americans have suffered from such "isolating mechanisms" as denial of citizenship, the right to own property, threat of deportation and lengthy incarceration in camps. The elderly are most affected by these events, which lead to distrust, feelings of helplessness and powerlessness, a fear of government, alienation from society and reluctance to use available public and social services. The limited availability of bilingual staff for the many languages spoken by the varying Asian groups is a major handicap for those seeking care. (6)
- Formal health care for the elderly Asian is an unfamiliar concept, especially if they are first, second, or third generation immigrants. They prefer self-treatment or treatment by a family member. In some Asian languages, there is no word for "illness." (6)

Adolescents

- Although information is scarce on the minority female adolescent, it should be noted that the major cause of disability among adolescents is mental disorder. (9) Some 10-12 percent of children and adolescents are thought to suffer from mental disorders. (2)
- It is estimated that rates of depression among the adolescent clinical female population may range from 3 percent to 33 percent. (3)

- Factors leading to mental problems among adolescent females include low parental support, low self-esteem, low levels of attachment to either parents or peers, and authoritarian or depressed parents. An unstable family life is a major factor in 50-80 percent of all adolescent suicides. (3) Girls 14 to 18 years of age have a higher incidence of depression than their male peers. There are higher rates of eating disorders among females than males, and in adolescence, females are two to three times more likely than males to be sexually abused. (3)
- School failure may accompany depression in the adolescent female, affected by class placement or learning disabilities. (3)
- Teen females bear the largest share of the physical, psychological, social and economic stresses of teen pregnancy. (3)
- It was estimated in 1989 that 10,000 cases of bulimia and 11,000 cases of anorexia were diagnosed. Although the majority of eating disorders are found among White females, they are present in all races. (10)

Lesbians

- The major reason for a lesbian to seek counseling is depression brought on by lack of social support, discrimination, homophobia, family rejection or termination of a relationship. Suicide rates for Black and Hispanic lesbians are 27 percent and 28 percent respectively, while for White lesbians the rate is 16 percent. Black and Hispanic lesbians are at increased risk for suicide attempts and for sexual abuse. (3)
- Minority lesbian women are generally ignored in most research, and particularly the Native American lesbian. Risk factors for these women are race and sex discrimination, alcohol and drug use, interrupted social ties, and threats of blackmail or exposure. Adolescent lesbians are three times more likely to attempt suicide. (3)

Other Concerns

- Chronic disease, especially among older minority women, can be a major risk factor for mental illness. Having to give up employment, sexuality, membership in groups, and recreational outlets are stressors. Others may include having the husband leave, social isolation, anger, negative changes in body image due to surgery or treatment, giving up control, worry about possible contagion (e.g., AIDS), and concern about financial resources. (11)

- Access to mental health services is a major problem for many minority women. The following tables provide information on use of mental health facilities by White and minority women.

Female Mental Health Outpatient Care in the United States
1986

	Whites	All Other Races
Number under outpatient care—4/1/86	617,574	94,170
Rates per 100,000 population	591.6	491.0
Outpatient admissions—1986	861,959	147,916
Rates per 100,000 population	825.7	771.2

Female Mental Health Inpatient Care in the United States
1986

	Whites	All Other Races
Number under inpatient care—4/1/86	51,297	14,375
Rates per 100,000 population	49.1	74.9
Inpatient Admissions—1986	537,688	143,038
Rates per 100,000 population	515.1	745.8

Source: Mental Health United States, 1990, U.S. Department of Health and Human Service, Public Health Service, Alcohol, Drug Abuse and Mental Health Administration, pp. 155-166.

- Of interest in the preceding tables are the rates for inpatient care for other races, which are higher than those for Whites. This contrasts with those for outpatient care, which are lower than those for Whites. Either minority females delay treatment until they have reached severe stages of mental illness, or they suffer more severe mental illness than their White counterparts. Access to mental health services is hampered for the minority female by lack of insurance or financial resources, lack of awareness of services, and often a distrust or fear of the system.

Issues

- Major gaps in research data exist for minority women and their mental health problems. Because of the diverse groupings of Indian tribes, Asian/Pacific Islander subcultures and the Hispanic subgroups (Puerto Rican, Mexican-American, Central/South American, etc.), and the differing cultural beliefs, mores, customs and languages of all the minority groups, research that considers these factors is needed to assure culturally sensitive services for them. A lack of access to services is a major barrier which must be overcome for women of color.

References

1. White, Evelyn C., ed. *Black Women's Health Book: Speaking for Ourselves.* Seattle, Washington: The Seal Press, 1990.

2. *Healthy People 2000: National Health Promotion and Disease Prevention Objectives.* United States Department of Health and Human Services, Public Health Service, September 1990, pages 208–219.

3. *Women and Depression: Risk Factors and Treatment Issues.* Final Report of the APA's National Task Force on Women and Depression. Washington, D.C.: APA, 1990, pages 15–39, 75–95.

4. *Women's Health: Report of the Public Health Service Task Force on Women's Health Issues, Volume II.* U.S. Department of Health and Human Services, Public Health Service, October 1987, pages IV.26–43.

5. Yee, Barbara K. "Gender and Family Issues in Minority Groups." In *Gender and Aging: Generations, Journal of the American Society on Aging,* Summer 1990, pages 22–24.

6. Baker, Kanikora, Espino and Manson. "Rehabilitation in Ethnic Minority Elderly." In Stanley J. Brody, J.D., M.S.W., and L. Gregory Paulson, M.D., M.P.H., *Aging and Rehabilitation II: The State of the Practice Edition,* 1990.

7. "Indian Women's Health Care: Consensus Statement." United States Department of Health and Human Services, Public Health Service, Indian Health Service, January 1991, pages 18–20.

8. "Older Chinese Women at High Risk for Suicide." In *Closing the Gap: Homicide, Suicide, Unintentional Injuries and Minorities,* United States Department of Health and Human Services, Public Health Service, Office of Minority Health, 1990.

9. *The Health of America's Youth.* National Center for Education in Maternal and Child Health, page 22.

10. Farley, Dixie. "On the Teen Scene: Eating Disorders Require Medical Attention." In *FDA Consumer,* March 1992, Volume 2, Number 2, pages 27–29.

11. MacElveen-Hoehn, A.R.N.P., Ph.D. "Mental Health During Chronic and Life Threatening Illness." In *Region X: Proceedings of Women's Health Issues Conference,* United States Public Health Service, Seattle, Washington, 1992, pages 84–98.

Focus Group Reports

Background

Fifteen focus groups met during the Forum to discuss each major track topic from the perspectives of (1) ethnic or racial influence; (2) the life cycle of the woman from menarche (onset of menstruation) through young adulthood, midlife, maturity and the elderly years; and (3) interagency linkages or systems challenges. Three focus groups addressed each one of the five track topics from the standpoint of one of these perspectives. The focus group reports follow.

FOCUS GROUP I—RACIAL OR ETHNIC INFLUENCES

Problem Societal and cultural insensitivity

Interventions

1. Equitable allocation of resources
2. Scholarship programs for minority-sensitive trained personnel who will then provide appropriate services to women of color
3. Cultural sensitivity education for service providers and the ethnic community

Barriers

1. Lack of statistical data
2. Lack of political advocacy for mental health issues at all levels (local, state, federal)
3. Funds not allocated for services
4. Lack of commitment at the community, state, and national levels.
5. Lack of valid perceptions of all ethnic groups

FOCUS GROUP II—WOMEN'S LIFE CYCLE

Problem

Mature adults (45-59 years), many of whom are members of the "baby boomers" group and who comprise one of the largest consumer groups, are most affected. This group is in an era of looking back at their lifestyle and their life's expectations.

Significant Issues

1. Accumulated anger due to
   a. Past violations, e.g., sexual, batterings, discrimination
   b. Accidental events such as deprivation (both physical and emotional), natural disasters such as earthquakes, etc.

2. Accumulated stressors
   a. Existing health problems of self and others
   b. Care and nurturing
      1. self-neglect and abuse
      2. spouse
      3. child care issues
      4. aging parents
   c. Discrimination based on age, gender, ethnicity or economic status
   d. Aging—losses of physical appearance, youth and spirituality, economic power, and opportunity; facing the reality of what has not been accomplished

3. Multiple demands
   a. "Sandwich" generation demands
   b. Expenses of children (college, marriage)
   c. Work versus retirement issues

4. Resultant effects of emotional stresses—chronic physical health issues such as cancer, heart disease, etc.

Barriers

1. Incomplete family unit
2. Angers not recognized—frustration due to past traumas surfacing
3. Language, cultural, economic and educational barriers
4. Lack of supportive resources

5. Denial of problems
6. Existing family dysfunction—e.g., alcoholic spouse
7. Lack of accomplishment leading to a life cycle resolution of despair/integrity
8. Changes in the family structure
   a. empty nest syndrome
   b. death of spouse
   c. children moving back into home
9. Double standard redefined (the new status of women, seeking new directions in conflict with the spouse's life cycle)
10. Accessibility of mental health resources

Interventions

1. Develop an instrument to identify mental health issues which views the individual as whole.
   a. Develop an instrument to screen for both mental and physical health problems, to be used by health professionals especially for referral.
   b. Develop a generic laymen's instrument for mental health assessment to be used in public education and for public distribution.
2. Self-help groups should assist in the formation of the instrument.
3. Encourage mentoring and modeling programs within the neighborhood to demonstrate accountability and responsibility.
   a. Formal/ structured program
   b. Informal—identify and utilize persons of influence within neighborhood
4. Encourage a network of community members to help each other—use the resources within.
5. Educate and create awareness of the psychosocial issues of aging changes so that women may constructively and assertively (versus aggressively) cope with their anger and stresses.
6. Educate the health care provider to make appropriate referrals based on accurate assessment of the patient.

FOCUS GROUP III—INTERAGENCY LINKAGES OR SYSTEMS CHALLENGES

Brainstorming

1. Lack of people of color providing services
2. Access to services
   a. Lack of on-site services in schools, neighborhoods, etc.
   b. Transportation
   c. Outreach
3. The stigma of mental health problems
   a. Mental health services must be seen in a more positive light
   b. Mental health services must build on cultural strengths
   c. Self-esteem
4. Stereotypical view of the role of women
5. Home visits—underserved areas

Problem

Women of color and underserved populations are affected to a great degree by depression, and this is aggravated by such factors as racism, lower educational and income levels, low status/high stress employment, immigration and acculturation, larger family sizes, marital dissolution, single parenthood and poor health. Diagnosis of mental disorders is a major concern among people of color in general. Crucial to amelioration of these problems is adequate access to mental health services.

1. Requirements for access to services:
   a. Health care providers who are culturally competent and sensitive and who build on cultural strengths
   b. Proactive outreach programs (home visitation)
   c. Available transportation
   d. Coordination of services involving consumers
   e. Health insurance coverage (including mental health) for everyone
   f. A system which addresses women's issues such as self-esteem and overcoming stereotypes
   g. Dollars for transportation costs, child care, required co-payments
   h. Community responsibility and awareness

2. Barriers to access:
   a. Lack of outreach (must be culturally appropriate)
   b. Lack of interface among providers (coordination of services)
   c. Legislation
   d. Low self-esteem of women of color
   e. Stereotypical role of women
   f. Working poor and low-income women without insurance
   g. Discounting of women's issues (lumping problems into categories of stress, depression, etc.)

Interventions

1. Coalitions which include consumers in planning and implementation
2. Advocacy groups
3. Incentives for providers to serve underserved consumers, e.g., loan deferral
4. Build on cultural strengths, accept and embrace cultural differences (trained staff), and provide education
5. Aggressive ethnic recruitment starting young with career development education from pre-school and continuing through high school
6. Neighborhood satellites
7. Community involvement
8. Legislation—federal, state, local, institutional
9. Dollars from private industry

Barriers to Intervention

1. Turf issues, inability to work together, lack of participation and communication
2. Organizations having goals and objectives which are too political
3. Funding stereotypes
4. Fear, bias, concern for money (low salaries)
5. Lack of money for scholarships and salaries, discrimination, stereotypes, antiquated school systems which are not progressive, lack of candidates for educational programs

6. Dollars for physical plants, lack of support from legislators and other decision makers
7. Apathy, hopelessness, lack of money, low-income working poor people who work and can't volunteer, lack of child care
8. Lack of sensitivity, lobbying
9. Having a different set of priorities, bureaucracy, lack of knowledge and a lack of organized lobbying efforts

Mental Health Track Report

Women of color are faced not only with the mental health problems common to all women, but with additional aggravations when these problems are coupled with racism, sexism, and the stressors of poverty and lack of education. The track group felt that the woman most affected by mental problems is the mature woman aged 45 to 59 who may also have to suffer the discrimination brought about by aging and possible losses associated with this age, including children, spouse, economic stability, and unfulfilled ambitions. The stigma of mental health problems, the lack of available and accessible resources for her problems, and the need for a strong and culturally sensitive support system make mental health issues a primary concern for women of color.

The track group which looked at this problem provides the following recommendations:

1. The community needs to become involved in the process of helping women with their mental health needs. It should take responsibility for rebuilding and re-identifying women's coalitions and support groups to provide women of color a protected and supportive environment in which to try to work through their problems. The community needs to make its women of color aware that these groups exist and provide easy access for women wishing to become involved in them.

2. In order to assist in their own solutions, women need to mobilize to be advocates for mental health issues. A more aggressive approach is required so that society, mental health providers, legislators, and others who can make change in the system will listen.

3. Because "mental illness" often carries a stigma which can prevent women from seeking help, it is necessary to promote the concept of "mental health." This will help to define mental health services in a more positive manner and contribute to earlier diagnosis and treatment of problems.

4. In an era of scarce resources, women will have to utilize existing community resources and begin to develop partnerships which might help expand funding and other resources. Groups to be approached include businesses, private industry, civic groups, religious organizations, social groups and the political arena. All these groups can benefit from having "mentally healthy women" in society, and can be approached from that perspective.

5. In order to facilitate an equitable allocation of funding resources for mental health services for women of color, it is important to be able to document the need for such funding. Documentation depends in turn on having access to quality statistical data. Channels for obtaining such data will have to be developed.

6. Recognizing that political clout is required in order to get help from government entities, women of color must increase advocacy for mental health issues at the local, state and federal levels. Such "clout" will have to be developed through the enlistment and training

of a large constituency of supportive individuals, with minority women at the core.

7. Those who make policy for the mental health system at all levels of government should be people who are culturally sensitive and representative of people of color. Government agencies should aggressively recruit and educate such individuals to insure that such policies reflect the varying cultural, linguistic and ethnic needs of the population.

8. Women of color need to be made aware of the issues surrounding mental health and the resources available to them for resolving these issues. Funding should be given to ethnic women's coalitions and groups so that they might make use of the appropriate media channels to increase awareness.

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Substance Abuse & Minority Women

3

Background Paper

It is important to recognize that the abuse of chemicals—alcohol and drugs (prescription or illicit)—is linked to emotional and mental illness and is a factor in violence against women, chronic illnesses, poor pregnancy outcomes, the transmission of HIV/AIDS, and unnecessary death. Any discussion of women's health issues will usually include the effects of substance abuse on the physical or mental disorder being considered.

ALCOHOLISM AND ALCOHOL ABUSE

> "I fell in love with a baseball player and got pregnant. I drank all through pregnancy. — Well, I lost that baby, and then I drank about that."
>
> from "Black, Female and Sober" by Lulu F. (as told to Rachel V.)

- Of the estimated 15 million alcoholics in the United States in 1990, almost 5 million (about one-third) are estimated to be women. The effects of alcoholism upon women are more severe than for men. (1) A significant number of alcoholic women are cross-addicted to alcohol and other drugs. (2)
- Two to eight percent of females are considered heavy drinkers (14-plus drinks per week). (3)
- Among those women of childbearing age, some 15 percent experience problems with alcohol and/or other drugs. (1,4) Alcohol is the major cause of mental retardation when used during pregnancy. (1)
- Dependence upon alcohol appears to be greater among middle-aged women. (1,4)
- Misdiagnosis of alcoholism in women is common. (4)
- Some 90 percent of alcohol abusers are also nicotine dependent. (5)

Substance Abuse and Minority Women

Problems

- Alcohol causes liver disease and chronic pancreatitis and can damage the heart. It is also associated with brain damage; memory loss; failures of the reproductive system; cancers of the mouth, larynx and esophagus; and dental problems. (5)
- Women are more likely to suffer acute and chronic health problems from alcohol than are men, and the percentages of women who die of suicide, accidents, diseases of the circulatory system and cirrhosis are higher than of men. (3)
- Fetal alcohol syndrome (FAS) results when pregnant women abuse alcohol and may cause growth retardation, abnormal face and head features or central nervous system abnormality among their newborns. (3)
- Women suffer more guilt and shame for their alcoholism than men, because drunkenness is viewed as worse for women. (2)
- Many alcoholic women die prematurely and many suffer sexual dysfunctions because of their abuse. (2)

Minority Women

- Alcohol causes more health-related problems among minority women, particularly Black and Native American women. They use alcohol, generally, as an escape from problems and their depressed conditions. (2)

—Black Women

- Despite a decline in cirrhosis rates among all minority groups, rates are disproportionately high among Blacks (male and female). (6)
- More Black women tend to abstain from alcohol than White (46 percent and 34 percent, respectively), and equal proportions of both groups drink heavily; however, more Black women suffer health problems from their drinking. (1)
- According to a national survey, 38 percent of Black women are heavy drinkers compared to 11 percent of White women; and Black women are about age 35 when they enter treatment programs—White women are 31. (7)

—Hispanic Women

- The Hispanic female tends to abstain from alcohol or to be a light drinker. (6)
- A few studies of Mexican-American women indicate higher cirrhosis death rates than for the general population. (6)

—Asian Women

- There is very little information on alcoholism in the Asian/Pacific Island female population. The different subgroups of Asians have differing drinking patterns. (6)

—Native American Women

- Among Native American women, alcohol abuse is one of the leading concerns. Their rates of alcoholism are consistently higher than those for the U.S. female population. For example, during 1985-1987, the rate per 100,000 population for the Indian female 35 to 44 years of age was 33.4, but for the U.S. female population 4.1.

  Rates for other age groups are 51.2 for Native American females and 7.7 for the U.S. female population for the age group 45 to 54; for the age group 55 to 64, the rate for the Native American woman is 47.5, and for the U.S. female 10.1. (8)

- In 1986–88, chronic liver disease and cirrhosis were the fourth leading causes of death for all Indians served by the Aberdeen and Billings Indian Health Service areas, which provide services in North/South Dakota and Montana/Wyoming, respectively. (9)

- In 1986–88, the Billings IHS had the fourth highest rate of alcoholism mortality (57.8 per 100,000) of all twelve IHS areas, and the Aberdeen IHS had the very highest (69.9 per 100,000). The rate for the combined IHS areas was 32.7 per 100,000. (9)

- Of Indian females in grades 7 through 9, 45.3 percent have ever tried beer/wine and 24.2 percent have ever tried hard liquor. Of those in grades 10 through 12, 79.9 percent have ever tried beer/wine and 46.2 percent have ever tried hard liquor. (10)

- Eighty-five percent of teenaged Indian females who drink are considered potential problem drinkers. (10)

- In 1979–1981 the death rates for chronic liver disease and cirrhosis for Native American women exceeded those of Hispanic, Black, Asian and White males. (8)

- A 1979 survey found that 43 percent of a sample of Native American drinkers were women. In the age groups 15 to 24 in 1985-88, the death rate from alcoholism for females exceeded that of males by 40 percent. (8)

DRUG ABUSE

> "In my work, I have observed generations of Black families on drugs: grandmother, mother, daughter, grandfather, father and son."
> from "Moving Targets: Alcohol, Crack and Black Women"
> by Sheila Battle

- A 1990 survey revealed that some 13 million Americans use illicit drugs. (11) Drug use has declined and seemingly stabilized since the early eighties; however, there has been an increase of 12 percent in drug-related visits to emergency rooms. (Cocaine-related visits rose 31 percent, heroin-related 26 percent). (12)
- Some six million women are reported to be users of illicit drugs. (4)

Problems

- Minorities tend to be more at risk for the hepatitis B virus, bacterial endocarditis and HIV/AIDS because of intravenous administration of drugs. (6)
- As many as 375,000 infants may be affected by drug use. (4)
- Women addicts tend to have more serious pregnancy complications. (3)
- Results of a 1988 survey of 36 hospitals (155,000 pregnancies) revealed that some 11 percent of pregnant women use heroin, methadone, amphetamines, PCP, marijuana and cocaine. (1)

Minority Women

- Drug-related morbidity and mortality among minorities, except for Asians, are greater than for Whites, and are greater in urban than in rural areas. (6)
- A recent study was done of drug-using women, 95 percent of whom were minority women whose mean age for their first drug use was 17.7 years. Fifty-six percent were polydrug users. Guilt and shame because of their addiction prevented them from seeking prenatal care when they were pregnant. (13)
- The most recent figures for minority female AIDS cases indicate that drug injecting is the most common category of exposure to AIDS, as can be seen in the following table:

MINORITY FEMALE AIDS CASES (14)

March 1992

	Exposure By Injecting Drug Use			
	Black	Hispanic	Asian/PI	Nat.Am.
Total number of cases	11,931	4,628	111	50
Number exposed through injecting drug use	6,569	2,304	17	29
Percent exposed through injecting drug use	55%	50%	15%	58%

- It is estimated that 71 percent of all female AIDS cases are linked, directly or indirectly, to intravenous drug use. (15)
- A telephone call on June 5, 1992, to the hotline of the Office of Substance Abuse Prevention provided results of a survey indicating that among women who had ever used drugs during the past year, 836,000 were Hispanic, 1,489,000 were Black and 9,425,000 were White.

Black Women

- Twice as many Black and Hispanic women were admitted for treatment of opiate addiction in 1981 as White women. (3)
- There is more drug use among Black homeless, and Blacks are three times more liable to be treated for drug problems than Whites (males and females). (6)
- A major problem is the number of Black women who use crack cocaine, become pregnant and have little or no prenatal care. "Crack babies" are difficult to care for and can cost millions to treat. (7)

Hispanic Women

- Hispanics are 2.7 times more likely to be in treatment for drug-related problems than Whites (males and females). (6)

Asian Women

- Because of their small population size, little is available on substance abuse among Asians. Also, Asians are often seen as the "model minority" who are immune to alcohol and drugs. (16)

- A study of Asian substance abusers in late 1989 revealed that 29 percent were women. (16)
- It is also estimated that Asian women overdose and die at a rate of 3 to 1 over Asian men and have a suicide rate 4 times higher than Asian men. (16)
- Asian women tend to deny and attempt to hide their addictions and thus don't seek help for their problems. (16)

Native American Women

- Native Americans (male and female) are twice as likely as are Whites to be in treatment for drugs. (6)
- Of Native American females in grades 7 to 9, 29.5 percent have ever tried marijuana and 48.4 percent of those in grades 10 to 12 have ever tried marijuana. (10)

Older Women

- A major concern for older women is the misuse of prescription drugs. Women make up 51 percent of the population, but they consume 60 percent of prescription drugs. (17)
- At risk for mixing alcohol and prescriptions are older people and alcoholics, and results can range from a minor annoyance to a life-threatening crisis. (17)
- Other concerns for elderly women are multiple drug use, duplication of medications, drug reactions, improper administration (over or under dosages) and expired medicines. (17)

CIGARETTE SMOKING

> "I'd say to myself, 'Oh boy, I deserve a treat. I haven't smoked for two months.' I'd light up and one cigarette would have me addicted all over again."
>
> from "Look for Guidance: How I Stopped Smoking" by Mary Lou Lee

Smoking is considered to be the major preventable cause of death in the United States, and the decline in the prevalence of smoking among the general population in the last few years has been very positive. However, millions continue to smoke. It is estimated that 400,000 Americans die each year due to cigarette smoking, 126,000 of them women. (1,19)

Problems

- Smoking is considered a causal factor for heart disease and other cardiovascular problems; cancers of the lung, larynx, oral cavity and esophagus; chronic bronchitis; and emphysema. Cigarette smoking is also associated with cancers of the urinary tract, bladder, pancreas and kidney; ulcer disease; and the birth of low-birth-weight infants. (6)
- Smoking by mothers is linked to poor pregnancy outcomes and to infant health problems. (19)
- Nicotine is considered to be the most addictive substance available today. Ninety percent of those who use nicotine become addicted whereas 10 to 20 percent of alcohol users become addicted. (16)

Minority Women

- For minority women, smoking prevalence is generally lower than for males. The decline in smoking is seen overall among minority women, but again, there are increases among adolescents. (18)

Black Women

- There are small differences in the prevalence of smoking among Black females and White females; however, Black females tend to smoke cigarettes with a higher tar content. (6)
- A study conducted of young Black female smokers in inner city public housing revealed that they either don't receive the message or don't believe that smoking increases the risk of lung cancer. Among this group, there was little support for those wishing to quit, and they were unaware of the availability of smoking cessation programs. (20)

Hispanic Women

- Hispanic females generally have lower smoking rates; however, there are increases in smoking noted for the adolescent female. A self-reporting survey indicated that female Hispanic adolescents exceeded both male and female White and Black adolescents in cigarette smoking prevalence. (6)

Native American Women

- There is limited data on cigarette smoking among Native American women, and there are great differences in prevalence among the various tribes.

- Of Native American females in grades 7 to 9, 46.3 percent have ever smoked (41.6 percent of males), and 54.2 percent of those in grades 10 to 12 have ever smoked compared to 50.1 percent of males.
- Girls are more apt to smoke on a daily basis than boys. (10)

Asian/Pacific Islander Women

- Again, the data on this group is scarce, but certain subgroups have higher rates of smoking than others.
- The incidence of esophageal cancer among Chinese females is 1.6 times higher than for White females, and the incidence of pancreatic cancer is 20 percent higher. (6)

Adolescents

- Adolescent and teenaged females are smoking at rates that exceed those of their male counterparts (31.6 percent and 28 percent respectively). (3)
- Every day 3,000 American young people become smokers. (21)
- Three-fourths of all adult smokers started smoking before age 18; 90 percent started before age 21. (21)
- Cigarette advertising which targets adolescents is effective, and the "Old Joe" (cartoon camel) ads have been shown to have their greatest impact on 12- and 13-year-olds. (21)

Issues

- Treatment programs for abuse are needed which are designed for women and which will provide for the child care needs of women who may need long periods of treatment.
- Research is lacking in the extent of the abuse problem in women, and particularly minority women. Prevention and education programs that will work are needed, as well as treatment modalities which take into account the cultural diversities of minority females.
- Minority women often do not seek treatment for their addiction problems because of economic or social problems, professional attitudes, stereotypes, guilt and shame, and a possible lack of awareness that help is available.

- Young people are not always aware of the health risks of substance abuse, but they also don't tend to worry much about these risks. Peer pressure is a powerful incentive to drink and smoke, as is targeted advertising by tobacco companies.
- Only six treatment programs exist for the Indian woman, and none of those are in this region.
- Treatment programs for minority women need to include the family, and particularly children.
- Prescription drug review teams in communities can be effective in monitoring drug use by the elderly.

References

1. *Primary Care-Substance Abuse Treatment Linkages: Focus on Women.* Alcohol, Drug Abuse and Mental Health Administration, NIAAA, NIDA, NIMH.

2. McGrath, et al., ed. *Women and Depression.* Washington, D.C.: American Psychiatric Association, 1990, pages 93–94.

3. *Women's Health: Report of the Public Health Task Force on Women's Health Issues.* U.S. Department of Health and Human Services, Public Health Service, 1987, pages IV.1–53, II.37–47.

4. Gyure, Michelle. "The State of Women's Health." In *Colorado Women News*, Denver, Colorado, April 1992.

5. *Alcohol Alert.* National Institute on Alcohol Abuse and Alcoholism, Number 14, PH 302, U.S. Department of Health and Human Services, Public Health Service, Alcohol, Drug Abuse and Mental Health Administration, October 1991.

6. *Report of the Secretary's Task Force on Black and Minority Health, Volume 1.* U.S. Department of Health and Human Services, August 1985, pages 129–143.

7. Battle, Sheila. "Moving Targets: Alcohol, Crack and Black Women." In Evelyn C. White, ed., *The Black Women's Health Book: Speaking for Ourselves.* Seattle, Washington: The Seal Press, 1990, pages 251–256.

8. "Indian Women's Health Care Consensus Statement." U.S. Department of Health and Human Services, Public Health Service, Indian Health Service, January 1991, pages 13–16.

9. *Regional Differences in Indian Health, 1991.* U.S. Department of Health and Human Services, Public Health Service, Indian Health Service, pages 34–44.

10. Blum, Robert, M.D., Ph.D., and Resnick, Michael D., Ph.D. *The State of Native American Youth Health.* University of Minnesota Hospital and Clinic, Division of General Pediatrics and Adolescent Health, February 1992, pages 41–45.

11. "Inside Public Health, Major Drug Abuse Survey Announced." In *The Nation's Health*, American Public Health Association, Volume XXI, Number 11, November 1991, page 9.

12. Greenhouse, Cheryl M. "Household Survey Shows Few Changes in Americans' Illicit Drug Use." In *NIDA Notes*, National Institute on Drug Abuse, Volume 7, Number 2, March/April 1992, pages 5–6.

13. Chavkin, Wendy, M.D., M.P.H. "Dialogues With Addicted Women: Lessons to be Learned." Abstract.

14. "HIV/AIDS Surveillance Report." Centers for Disease Control, April 1992, page 10.

15. *The Twin Epidemics of Substance Use and HIV: Report of the National Commission on Acquired Immune Deficiency Syndrome*, July 1991.

16. Inaba, Darryl S., Pharm.D. "Substance Abuse Among Asian Women." In *Region X: Proceedings of Women's Health Issues Conference*, U.S. Public Health Service, November 1990, pages 19–32.

17. "Women and Medicines." In *Talk About Prescriptions Month*, National Council on Patient Information and Education, October 1991.

18. *Smoking and Health in the Americas: A 1992 Report of the Surgeon General in collaboration with the Pan American Health Organization.* U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 1992, page i.

19. *Health United States 1990.* U.S. Department of Health and Human Services, Public Health Service, March 1991, page 30.

20. Manfredi, Clara, Ph.D., *et al.* "Smoking-Related Behavior, Beliefs, and Social Environment of Young Black Women in Subsidized Public Housing in Chicago." In *American Journal of Public Health*, American Public Health Association, Volume 82, Number 2, February 1992, pages 267–272.

21. "Students Getting Hooked on Smoking Habit Early." In *The Denver Post*, Denver, Colorado, March 29, 1992.

NOTE: All quotes are from articles found in *The Black Women's Health Book: Speaking for Ourselves*, edited by Evelyn C. White, Seattle, Washington: The Seal Press, 1990.

Panel Presentation

Health Issues of Minority Women

Substance Abuse and Minority Women

Martha J. Wunsch, M.D., F.A.A.P.

Maria was a fourteen-year-old Native American when I met her. Her mother had utilized me as a consultant in her program in the community and brought her to me for a "school physical." The mother was concerned that her daughter was sexually active and needed to be "talked to." After the briefest of examinations, I began talking alone with this young teenager. She had run away from home twice in the past six months after disagreements with her mother. I saw Maria several times and elicited further history from the social worker involved with the family. Maria had attempted suicide at age nine, and had been placed in a foster home twice. She had a 19-year-old sister who was pregnant for the third time. The older sister's two children had been diagnosed with Fetal Alcohol Syndrome and were in the grandmother's custody. Maria's father was an alcoholic and known to have been physically abusive with her, her mother, and her sister. He was also a known drug dealer in the community. Her mother was seen as successful in the community but reputed by her employees to be rigid and a perfectionist. At one of the office visits to follow up on labs and other details of the physical examination, Maria told me that her mom hit her when she had broken a house rule and was angry. I encouraged her to leave the home and go to a shelter the next time her mom began physically disciplining her. Two weeks later she ran from home to the shelter when her mom began beating her.

While she was in the shelter, Maria revealed what I had suspected. She had been using alcohol since she was eight years old, had used cocaine three times in the last year, and was using marijuana four to six times per week. She briefly alluded to sexual abuse in her past. Maria agreed to go to inpatient treatment for drug and alcohol abuse.

She came home from her thirty days of treatment, moved back in with her parents, and relapsed within two weeks. After thirty more days of inpatient treatment, she was able to maintain her sobriety. Her aftercare included returning to school, weekly counseling, and attendance at 12-Step meetings.

Six weeks after returning from treatment, Maria became pregnant. She maintained her sobriety, but never returned to school. She delivered a healthy, normal seven-pound daughter a year after returning from inpatient treatment. During her pregnancy she received weekly counseling, attended 12-Step meetings, and received case-managed prenatal care. The team supporting her included her obstetrician, pediatrician, aftercare counselor and social worker. After the birth, she moved away from her family. She lives with her boyfriend and his parents and is planning to seek some job training when her daughter is a year old.

Maria's story illustrates many facets in the life of the addicted woman and the issues she faces. She had been raised in an atmosphere of confusion secondary to drug and

alcohol use by one of her parents. This chaotic lifestyle of her family of origin placed her at risk for physical, emotional and sexual abuse. Her suicide attempt as a young child illustrated the depression she experienced. Evaluation of drug-dependent women by such scales as the Profile of Mood Status and Beck Depression Inventory find these women have high levels of confusion and depression. These reflect the chaotic upbringing they have experienced as well as the effects of drug and alcohol use in their own lives. Although her mother was currently employed, there had been years of extreme poverty for her family. The pregnant woman who is raised in such a dysfunctional family may place her own child and herself at risk by her own drug and alcohol use.

Maria continues to do well, remains sober 26 months after treatment, and is beginning to outline some plans for her future. Her older sister delivered another child with Fetal Alcohol Syndrome, and has been in jail. She continues to refuse treatment. The two sisters indicate the impact early treatment may have on the addicted or alcoholic woman.

Nationwide, several prevalence studies have looked at the rates of substance abuse among pregnant women. From 4 to 27 percent of women who are pregnant use a mood-altering substance. The incidence of Fetal Alcohol Syndrome varies between communities, but is 2.0 to 3.0 per 1000 births nationwide. Of women using drugs, 17 percent use cocaine, 28 percent use marijuana, 44 percent use nicotine, 59 percent use alcohol and 4 percent use opiates.

Women who use drugs and alcohol during pregnancy put themselves and their offspring at risk by exposure to substances with teratogenic potential. In addition, they also put the pregnancy at risk through three other mechanisms. The first, the use of intravenous substances, is the risk of dying from the vehicle itself. The user is exposed to the HIV virus, hepatitis, bacterial infections, and tetanus. She may trade sex for drugs, and contract any of the sexually transmitted diseases such as syphilis, gonorrhea and chlamydia. The second risk for her and the baby is that of sudden withdrawal from the psychoactive substance. This may result in loss of the pregnancy with fetal death. The third and most important risk is that of NOT getting prenatal care and appropriate nutrition. The chaotic lifestyle of the addict or alcoholic does not include finding prenatal care, keeping appointments or eating a nutritious diet.

The treatment for the pregnant addict or alcoholic must be supportive, multidisciplinary, available and flexible. The most important goal of all treatment team members must be support of chemical dependency treatment, aftercare, and continued sobriety. The primary diagnosis of chemical dependency must be kept in mind as prenatal, postpartum and newborn care are provided. The team consists of the physicians (obstetrician and pediatrician), clinical psychologist, behavioral therapists, social worker, parenting educators, and chemical dependency specialist. The multidisciplinary team providing care must have excellent, ongoing communication about the treatment plan. This will eliminate manipulation of the care providers, and streamline the multiple services necessary.

The multidisciplinary model must address multiple needs of the pregnant addict or alcoholic, while never losing sight of the primary goals of abstinence and sobriety. This is the ideal venue to carry out the five steps of the intervention with a pregnant chemically dependent woman:

1. State the indicators of the drug and alcohol problem to the woman.

2. Educate the patient/client about the possible effects on her fetus and the benefits of achieving abstinence and sobriety.
3. Express concern and refer for treatment.
4. Provide nurturing, structured, overall care for the biopsychosocial disease of chemical dependency.
5. Offer advocacy for the mother-child dyad in recovery, and outline the real consequences for continued use of substances.

The pregnant alcoholic or addict is a difficult client or patient to care for. She may appear angry, helpless, hopeless, or uncaring to the team charged with her care. She expresses the denial of any person with the disease of chemical dependency. She may feel anxious based on her assumptions, expectations and past experience with helping professionals. She may expect to be shunned or criticized. She may feel guilt and shame, especially in light of her pregnancy. Her community and family may be angry and intolerant toward her. Comments by caretakers designed to make her feel inadequate, guilty or ashamed will be magnified and utilized as excuses to not return for care. She may be chronically late or miss appointments, continue use of substances, and be involved in illegal actions to continue access to her drugs. She may be irritable, impulsive and demanding with her treatment team. These emotions may reflect her underlying issues, growing out of a depressed and chaotic childhood, amplified by her own drug and alcohol use. It is important that the attitudes of ALL providers and staff—from personnel scheduling appointments to educators, physicians and therapists—be non-judgmental and non-punitive.

A care plan must address the facts of the biological and physiological needs, psychological, behavioral and cognitive needs, and demographic or sociocultural needs which exist during the pregnancy. After the birth, the needs of the mother-infant dyad must be addressed, as well as the early childhood developmental needs of the newborn, infant, toddler and school-aged child.

The services provided by the treatment team must be community based, accessible and available. Indigenous workers provide the link to the community. They provide education to the community about pregnancy and exposure to drugs and alcohol. They will be the contact point for many women seeking help. They may be the primary referral system in a small community. Services must be scheduled and located to answer the needs of the client population. For example, on a rural Indian reservation, tribal health workers will transport to clinics and need to be intimately involved in scheduling. In a major urban setting, major bus routes need to be considered when setting up services.

In actuality, the treatment team must be prepared to "re-parent" the pregnant addict or alcoholic. They recreate the healthy family by providing nurturing care with definitive goals and a clear treatment plan. Their consistent, supportive and healthy attitudes will provide an optimally healthy milieu for the woman seeking recovery.

Focus Group Reports

Background

Fifteen focus groups met during the Forum to discuss each major track topic from the perspectives of (1) ethnic or racial influence; (2) the life cycle of the woman from menarche (onset of menstruation) through young adulthood, midlife, maturity and the elderly years; and (3) interagency linkages or systems challenges. Three focus groups addressed each one of the five track topics from the standpoint of one of these perspectives. The focus group reports follow.

FOCUS GROUP I—RACIAL OR ETHNIC INFLUENCES

Problems

1. Lack of equal access to services and treatment program
   a. Institutional—language
   b. Isolation (rural areas)
   c. Racism
   d. Cost
   e. Need for child care
   f. Family (for the inpatient)
   g. Age
   h. Men not trained to handle women's issues (cultural competence lacking)
2. Prevention
3. Poor self-esteem leading to various addictions
4. Children being given over-the-counter drugs by their parents at an early age
5. Gambling—transferred addictions
6. Co-dependency (part of the addiction process)
7. Acknowledging that there is a problem
8. Advertising which targets women and children and can lead to alcohol and cigarette addictions
9. Need for cultural competence

Issues

The issues can be summarized as three basic problems:

a. Access
b. Prevention
c. Self-esteem
— The major problem is ACCESS

Interventions

1. Prevention by identifying women with low self-esteem
2. Programs teaching self-esteem, particularly in the school system
3. Child care services provided with educational programs
4. Incentives to be in treatment—life skills, job skills, placement
5. Mobilization of the community, spiritual leaders, elders, family
6. Return to traditional values through the family, elders, spiritual leaders, language
7. Education of women in the history of minorities
8. Use of the media to teach and advertise social values
9. Use of bilingual staff
10. Education in cultural competence (our own and others) to build self-esteem
11. Affirmative action based upon ethnicity and gender
12. Education and awareness in order to remove stigmas
13. Education of doctors, nurses, care providers for appropriate referral
14. Treatment versus penalty within the legal system
15. Community outreach
16. Employer referral
17. School system
18. The need to teach parenting skills (day-care centers)

Barriers to Interventions

1. Attitudinal—feeling hopeless and helpless
2. No financial incentives for media to support change
3. Denial
4. No incentives for business to support change
5. Educational system
6. Lack of funding for services such as education, child care
7. Lack of women in higher administrative positions (discrimination)
8. Ownership of problems
9. Men
10. Racism
11. English-only requirements
12. Limited cultural awareness

Recommendations

1. Mobilize to elect women to offices (local, regional, state, federal)
2. Review of educational materials so they are not racially or sexually biased
3. Cultural training incorporated into school curricula
4. Women uniting so as to have a voice—empowerment by numbers
5. Using existing community dollars for community education
6. Utilize community celebrations regionally as a vehicle.
7. Education regarding recovery process to demystify it and assist in identifying addictive behavior
8. Public service announcements (PSAs) on substance abuse and family values
9. Women's advisory groups in government until women constitute 50 percent of administrative positions
10. Seek out non-alcohol and non-tobacco sponsors for events.
11. If an organization has offensive policies or offensive behavior, ask friends to write and request a change.

12. Co-operative child care efforts to support the recovering woman
13. Liaisons with universities to provide training in child care and parenting skills
14. National health insurance
15. Funding of women and family-based recovery programs to promote "ownership"

FOCUS GROUP II—WOMEN'S LIFE CYCLE

The group decided to focus on women in the age group 20-44 with a primary emphasis on alcoholism. The age group 20-44 was selected because this represents the largest number of women affected and because they are key individuals in society (i.e. caregivers, providers etc.)

Problems

1. Lack of "women appropriate" services
2. Defining the role of the male in women's substance abuse issues
3. Lack of self-esteem
4. Acceptance of the situation (i.e., the status quo)
5. Boredom and the expectation of instant gratification
6. Abusing substances to "escape"
7. Numbing the pain with substance abuse
8. Lack of support, lack of treatment services
9. Lack of focus on and attention to women's substance abuse
10. Lack of life skills and deficits in education
11. Lack of extended family and family supports
12. Denial
13. Thinking there's only one way to solve a problem
14. Cultural estrangement—women in crisis—mobile/congregate living

Interventions

1. Not accepting the status quo
2. Returning to "good neighbors," caring communities

3. Teaching, learning and using life skills
4. "Safe" havens
5. Resources to assist the abuser in recognizing personal responsibility with skilled personnel to provide continuing care
6. Long-term rehabilitation which includes healing and becoming a whole person
7. Active and positive role playing
8. Culturally appropriate care
9. Tolerance of differences

Barriers

1. Access, including available transportation
2. Children
3. Trying to provide for the basic needs of the family
4. Communications
5. Language
6. Literacy
7. Not recognizing that women have substance-abusing problems—over-labeling their problems
8. Lack of knowledge since minority women are not included in research studies
9. Feelings of hopelessness and fatalism—the problem is overwhelming
10. Lack of trust
11. Manipulation of the system by substance abusers
12. Lifestyle changes
13. The system is a barrier.
14. Fears of losing children or jobs, fear of being reported to "officials"
15. Finding substitutes for bad habits

Recommendations

1. Community-based programs to provide culturally appropriate services
2. Community coalitions
3. Use existing legislation which precludes sex, race, linguistic discrimination
4. "Women-appropriate" services
5. Outreach
6. Family-oriented services
7. Standards established by communities
8. Sharing successful models

FOCUS GROUP III—INTERAGENCY LINKAGES/SYSTEMS CHALLENGES

Problems

1. Mental health—correlation to alcohol problem
   a. Other links such as depression
   b. Treating addictions with chemicals
   c. Need for culturally appropriate treatment
2. Problem identification and referral
   a. Triage
   b. Primary care settings
   c. Social service agencies
   d. Schools
   e. Churches
   f. Emergency rooms
3. Gang activity and substance abuse
4. Spiritualism and cultural relevance
5. Breakdown of the family leading to multigenerational substance abuse
6. Attitudes of the media—practices, sponsors and role models that encourage substance use
7. Acculturation and literacy
8. Groups that fall through the cracks

Interventions

1. Include those who have experienced the pain of the problems as resources
2. Prevention and early intervention
3. Use of mentors
4. Community support
5. Use of volunteers

Systems of Care

1. Culturally competent counselors
2. Community wellness which views the community as a system
3. Fostering liaison and networking
4. Knowledge of substance abuse treatment and services
5. Youth/elder programs
6. Asian/Pacific Americans—parenting programs across generations
7. Residential treatment such as foster care and other sentencing alternatives
8. Job corps

Barriers

1. Geographic spread (long distances to services)
2. Difficulty of accessing services and establishing linkages
3. Lack of multicultural sensitivity
   a. Classes on health
   b. Food banks
   c. Seeking balance in the racial and ethnic focus of one's respective group so that it does not appear to be racist or isolationist
4. Not valuing cultural diversity
   a. Affects policy decisions
   b. Affects self-esteem
   c. Affects use or disuse of talent
5. Lack of funding
6. Educational failure
7. Improperly generalized research

Substance Abuse Track Report

Substance abuse has become a major problem among women of color, particularly in the younger woman aged 20 to 44. The track group concluded that four continuing problem themes exist for women of color and substance abuse: (1) a lack of self-esteem among women of color leading to varying forms of addiction; (2) low levels of literacy brought about by educational deficits, which in turn cause low employment levels and poverty; (3) denial that substance abuse exists as a problem for them; and (4) a lack of cultural competence at all levels, including both knowledge of one's own culture and knowledge of other cultures, and thus a lack of culturally appropriate services for substance-abusing women of color.

The track group recommends the following:

1. The existing social standards and values which define substance abuse as acceptable need to be redefined. This can be done through:

   a. Use of the media, public service announcements
   b. Local newsletters
   c. Local and community television channels (tribal television shows, for example)
   d. Involvement of churches, spiritual leaders, elders, etc. in mobilizing the community
   e. Use of professional marketing consultation to assure that these interventions are acceptable in the target communities (rap, for example)
   f. Utilize existing prevention groups, community leaders, existing information obtained from the Department of Health and Human Services and data from the regional office of the Public Health Service.

2. Programs need to be developed and utilized which will help women of color to achieve success and thereby help build their self-esteem. Ideally, programs will include the entire family (co-located or together).

   Such programs might include Head Start or elementary school with parents' classes held at the same time and place as the youngsters'. Classes might include parenting, GED, exercise, job skills development, or exercise classes (with children included), and should encourage volunteer activities. Other programs might take place at community centers or with existing prevention groups.

3. Volunteer groups should be organized at the local level that can be trained in cultural competence and can then provide such training to others. These cultural competence teams (or CCT's) can then provide education or inservices to school children, medical providers and the community in general, including community centers, churches, workplaces, libraries, etc. The support of governors and legislators should be obtained in order to provide the training to policy makers. Resources for such training include existing local and educational institutions, public libraries, the Office of Minority Health, and all the participants in the minority women's health forum.

4. There is a need to capitalize on existing laws and regulations in order to help decrease discrimination. Again, all of us should be involved in this. Other mechanisms to be utilized include the Office for Civil Rights and the U.S. Department of Health and Human Services. The fact sheets distributed by ACT UP in the lobby today should be taken back by all of us to share with organizations in our individual states to provide community education on a limited basis.

5. We need to advocate for funding for substance abuse treatment programs that focus on women and the family. We can all write to our congressmen and to the Office of Substance Abuse Prevention, the Maternal and Child Health Bureau, Office of Minority Health and Office on Women's Health.

6. We need to reach our children and help to re-focus them early through self-esteem groups. We can target community, YM/WCA and church activities to minority children via outreach that addresses such barriers as transportation, need for role models, etc. Schools should include cultural competence training and the presentation of successful models for students. Existing resources can be used for this.

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Violence & Minority Women

Background Paper

"There are many traditions that support violence against women. The abuse you are suffering is being experienced by millions of other black, brown, yellow, red and white women all over the world."

from "Love Don't Always Make It Right: Black Women and Domestic Violence" by Evelyn C. White in *The Black Women's Health Book: Speaking for Ourselves*, Edited by Evelyn C. White

"But we cannot begin to overcome the insecurities and self-hatred that contribute to the abuse in our lives until we take an honest look at why these feelings exist."

from "Love Don't Always Make It Right: Black Women and Domestic Violence" by Evelyn C. White

FAMILY VIOLENCE

Spouse Abuse

- It is estimated that 4 to 5 million women are assaulted each year in their homes by husbands, former husbands, boyfriends or lovers (1). Results of a national survey revealed that in 12.6 percent of all couples (1 of every 8) there has been at least one abusive episode in the marriage. (1) Some 12-15 million women have been beaten in the past. (1)
- About one million women use emergency medical services each year, and between 30-50 percent of all rape victims seen in the emergency room are battered women. (2)

- In 1986 some 115,000 women made use of shelters for battered women, but 330,000 were not able to be served due to lack of space. (2) And although abuse may be the single most common source of serious injury to women, in a 12-month period, only 52 percent of battered women contacted the police. (2) Other highlights of this problem are
  - an estimated 40 percent of all female injury episodes are presented by battered women; (2)
  - twenty-six percent of all suicide attempts by women are preceded by abuse; (1)
  - ex-spouses are responsible for 19 percent of domestic violence; (2)
  - one in five pregnant women is battered, and although battered women are pregnant more often, they carry their babies to term less often; (3)
  - 45 percent of mothers of abused children are battered; (2)
  - battering may be present in 25–53 percent of pregnancies; (4)
  - low birth weight infants are born to 6.6 percent of nonbattered women, but to 12.5 percent of battered women. (4)

Risk Factors

- Risk factors for battering include women who have higher occupational or educational status than their partner, mixed religion marriages, the presence of firearms in the home, younger women, such isolating factors as language differences, an unemployed or underemployed male and Black women (there is uncertainty as to whether Black women are more willing to report abuse or whether low socioeconomic status may be the actual risk factor).
- Other general contributors to violence are cultural attitudes which define wife-beating as acceptable, the availability of weapons, media portrayals of violence as entertainment, disrupted families, overcrowded and substandard housing, discrimination against minorities, a lack of adequate social supports, and male belief systems which state that "violence is a legitimate way of solving problems" and "it's okay for a man to control a woman." (2)

- The high costs of spouse abuse, a preventable public health problem, may include multiple visits to medical and psychiatric providers. Abusive injury is a factor in 35 percent of all rapes, 50 percent of all cases of female alcoholism, and 26 percent of suicide attempts; 45 percent of mothers of abused children are battered. (1)
- Unfortunately, when battered women try to seek help, they are often labeled as "hysterics," hypochondriacs," or "women with multiple complaints." (1)

Minority Women

- Of the four minority groups, Black women are at greatest risk of abuse (maybe two or three times greater than White women). Blacks comprise 45.4 percent of victims of spouse homicides (8.4 times higher than Whites) and are at greater risk of nonfatal abuse. (5)
- Among Southeast Asian women, there is an expectation that they will defer to their husbands, and male dominance is accepted. Some Asian cultures feel that it is the husband's right to beat his wife if needed, and family needs are put before those of any individual family member. (4)
- Additional problems for Asian women may include cultural and language barriers to seeking help and possibly a lack of knowledge of available supports.
- Chinese women over 45 years of age have higher rates of suicide than those for White women of the same age. The risk of suicide in these women increases with age. (6)
- While statistics are scarce for the Hispanic female, the following statement by a Hispanic male suggests perhaps that spouse abuse just possibly may exist in this culture:

> The machismo of the Hispanic male is not a negative thing. Understand that it is pride, true pride in being a man, one who is strong, one who loves and wants to provide for and protect his family.
>
> When a man finds he cannot do these things—sometimes he goes into a rage directed at himself or the people he loves the most, his family. (7)

- For Native Americans, the statistical emphasis is on the high numbers of unintentional injuries, often attributed to alcoholism. A report, however, from the Indian Women's Health Care Round Table, states that the incidence of abuse of women "is on the rise in Indian country." (8)
- Tribal councils and other agencies' refusal to recognize the problem, the deterioration of the family structure, alcoholism, and a history of oppression have combined to devalue the woman in the Indian culture.
- A survey of Native American adolescents indicates that 9.9 percent report ever having been sexually abused by family members or other, 7.8 percent having ever been physically abused and 6.3 percent having been both physically and sexually abused. (8) For these young women, such abuse can be the start of a lifetime of victimization.

Child and Adolescent Abuse

- It is estimated that more than 930,000 children in the U.S. experienced either child abuse or neglect during 1986. Of these, some 1,100 died. Child abuse includes physical, emotional and sexual abuse, and neglect involves physical, emotional and educational neglect. Rates for non-fatal child abuse and neglect increase with age, peaking between 12 and 14 years of age. (9)
- In 1986, more than 820,000 children experienced non-fatal injuries related to child maltreatment, with 17 percent having injuries which were life-threatening or which entailed potential long-term impairments. Again, these non-fatal injury rates tend to increase with age, with the highest rates for both serious and moderate injury at ages 15 to 17. (9) Females are abused at higher rates than males, and are four times more likely to be sexually abused than males. Low income, rather than race, is a significant risk factor for abuse and neglect of children. (9)
- Forty-five percent of mothers of abused children are battered women, and these children are at risk for such problems as sleep and eating disorders, depression, nightmares, respiratory distress, and various physical complaints. (2)
- Mental health and substance abuse service providers to Native Americans are finding that the majority of women they treat

are adult survivors of sexual abuse. Permanent emotional and psychological damage are often the results of child abuse, with studies of institutionalized adults revealing that a great number had been abused as children. (8)

- A boy who sees his mother being abused is 700 times more likely to become an abuser and, if he is abused, 1,000 times more likely. Girls seeing their mothers abused feel that this is how relationships are supposed to work. (3)
- A recent article in the *Denver Post* points out that "two-thirds of teenage girls who become pregnant were sexually abused as children," noting that "The United States has both the highest rate of teenage pregnancy and the highest reported levels of childhood sexual abuse in the industrialized world." (10) In a related article, the problem of dating violence among adolescents is reported on, and it states that "twenty-eight percent of teens have experienced dating violence," which can include sexual as well as physical abuse. Only three states (Colorado is one) provide protection for persons under 18 from violence in dating relationships. (11)
- The belief that "children belong to their parents" is quite pervasive in our society, and may be used to explain why there is a general reluctance to address the child abuse problem. (2) Again, the condoning of violence by society contributes to its perpetuation.

RAPE AND SEXUAL ASSAULT

- During the period 1973 to 1982, 1.5 million women (100,000 per year) were victims of rape or attempted rape. (2) Included in the broad categories of rape are stranger rape, acquaintance rape, date rape and marital rape.
- In 1986, 73 of every 100,000 females were victims of the 90,434 rapes reported to the FBI and eighty percent of the cases of forcible rape. (2) The National Crime Survey estimates that 120 of every 100,000 women are victims of rape, and there are some who feel that the numbers may be seven times higher than this. (2) Underreporting is a major problem, with one estimate that only one in five rapes is reported and another that one in 20 is reported. Reasons for underreporting include the FBI's "unfounding" process under which a case

may be dismissed if the report isn't considered believable. Shame, guilt, fear of disbelief, social stigma and requirements in some states of evidence of resistance (to the rapist) also deter women from reporting rape and sexual assaults.

- Total medical costs of sexual assault during the period 1973 to 1982 were almost $73 million. (2) Other costs include physical injury (bruises, black eyes, cuts) and rape trauma syndrome which includes stress symptoms (fear, humiliation, disbelief, rage, disturbed eating and sleeping patterns), flashbacks, loss of concentration, acute anxiety, nightmares, denial, disrupted sexual lives and coping efforts.
- The young single Black female from a low-income urban area is at highest risk for rape, with the peak ages for rape between 13 and 19. In one study, rape was 12 times more frequent for Black than White women, even though Blacks were only 10 percent of the population. (2) Rape can happen to any woman regardless of age, race, social class, educational level or occupational status.

ELDER ABUSE

- In 50 years, 20 percent of the U.S. population will be over 65 years of age. Currently the percentage is 13. (12) We are living longer, but we are more disabled and dependent, bringing about increased reports of abuse and neglect of elders. Unfortunately, no major studies have been done on elder abuse, but estimates range anywhere from one to ten percent of elders have been abused. (2) As with other forms of abuse, elder abuse is underreported—perhaps only one in six to fourteen cases are reported. There are fears of revenge or removal from one's home, and a reluctance to publicize family affairs. (2)
- Adding to the elder abuse problem is the lack of resources to provide the care needed by the increasing numbers of elderly who are more severely disabled. Women working outside the home, the increasing rate of divorce, more single-parent families, and the mobility of the modern family make it more difficult for the older relative to be cared for in the home. And when families do attempt to care for their elders at home, the task often becomes an "intolerable financial, physical and emotional" burden. (12)

- A disproportionate number of abused elderly tend to be women, but because of the lack of valid information on this problem, it is difficult to determine other risk factors such as race. It is generally accepted, however, that the composite abused elderly person tends to be a White female. (2)
- In addition to the abuse in the home by family or other care-givers, institutional abuse of the elderly is also a problem. Studies of nursing homes and board and care homes still uncover evidence of physical and psychological abuse, sexual abuse, neglect and other rights violations of the elderly, despite efforts to end these behaviors.
- It's only been since the late 1970s that elder abuse has begun to emerge as a serious problem which needs society's attention. In the *Report from the Secretary's Task Force on Elder Abuse* published in 1991-92, one strong recommendation is for a "comprehensive research strategy on the prevalence and causes of elder abuse and neglect." (13)
- The only state data available is for homicides, and this is presented below.

Total Deaths by Race due to Homicide per 100,000 Population (4) 1988

State	Total	Whites	Blacks	Others
Colorado	5.8	4.8	31.2	1.2
Montana	4.2	3.6	50.2	11.6
North Dakota	1.4	1.4	0.0	23.5
South Dakota	4.5	1.5	0.0	37.4
Utah	3.2	3.0	0.0	8.9
Wyoming	2.7	2.3	25.8	8.1

Issues

- There is a serious lack of adequate and reliable data on abuse in Region VIII; therefore the problems are greatly underestimated.
- Health and human service providers need help in order to provide appropriate care for victims of violence.
- Consideration of cultural differences is needed when working with abused women who are minorities.
- Society's views of violence as acceptable need to be examined and rejected when inappropriate.
- Resources need to be targeted and/or re-programmed toward the problems of family abuse and violence.

References

1. Rosenberg, M.L., Stark, E. and Zahn, M.A. "Interpersonal Violence: Homicide and Spouse Abuse." In J.M. Last, M.D., D.P.H., ed., *Public Health and Preventive Medicine*, Twelfth Edition. Norwalk, Connecticut: Appleton-Century Crofts, 1986, pages 1399–1424.

2. The National Committee for Injury Prevention and Control. *Injury Prevention: Meeting the Challenge.* New York: Oxford University Press, 1989, pages 192–201 and 213–250.

3. Gaines, Kathy, R.N., B.S.N. "Women's Health Issues." Seminar Presentation for Centennial Area Health Education Center, Greeley, Colorado, January 10, 1992.

4. *Violence and Victimization: An Annotated Bibliography.* Bethesda, Maryland: Nova Research Company for the National Institute on Drug Abuse, September 1991.

5. Mercy, J.A., Ph.D., and Saltzman, L.E., PhD. "Fatal Violence Among Spouses in the United States, 1976-1985." In *American Journal of Public Health*, May 1989. V.79:5, pages 595–598.

6. *Report of the Secretary's Task Force on Black and Minority Health, Volume I, Executive Summary.* Washington, D.C.: U.S. Department of Health and Human Services, August 1985.

7. Utah Department of Health, Ethnic Minority Health Committee. *Final Report: First Annual Statewide Ethnic Minority Health Conference*, Salt Lake City, Utah, April 17-19, 1991.

8. *Indian Women's Health Care Round Table: Final Report.* Indian Health Service, Office of Planning, Evaluation, and Legislation, Tucson, Arizona, January 1991, pages 20–22.

9. Children's Safety Network. *A Data Book of Child and Adolescent Injury.* Washington, D.C.: National Center for Education in Maternal and Child Health, 1991, pages 42–46 and 50–54.

10. "Abuse, Teen Pregnancy Linked." In *The Denver Post*, March 19, 1992.

11. Dating Violence Among Adolescents Gaining Attention. In *The Denver Post*, March 19, 1992.

12. Douglass, R.L., M.P.H., Ph.D. *Domestic Mistreatment of the Elderly: Towards Prevention.* Washington, D.C.: American Association of Retired Persons, 1988.

13. *Report from The Secretary's Task Force on Elder Abuse.* Washington, D.C.: U.S. Department of Health and Human Services, 1992.

14. Bureau of Health Professions' Area Resource File (ARF) System. *Selected U.S. and State Demographic Summaries for the Minority Health Network.* Fairfax, Virginia: Quality Resource Systems, Inc., November, 1991.

NOTE: Quotes are taken from articles in *The Black Women's Health Book: Speaking for Ourselves* edited by Evelyn C. White, Seattle, Washington: The Seal Press, 1990.

Panel Presentation

Violence and Minority Women

Jacqui Cunningham, L.C.S.W.

"Violence—An Open Letter"

I'd like to share a little something with you this day. When I was asked to speak at this forum, I was excited yet hesitant. When I spoke to Charlotte Gish, the excitement increased until . . . now I don't know if she recalls this, but if she does she'll confirm that there was dead silence on my end of the phone when she said that I was reported to be an expert on violence. I began at that moment, and have continued up to this very moment, to re-think my beliefs and to heighten my observations. In my everyday employment, I'm a clinical social worker in a pediatric medical setting. In this capacity, I work with health issues, parenting, child abuse and child development. As I began my re-thinking, I realized that my job also involves dealing with violence on many levels and that these levels are both cyclic and intertwined. In cases of child abuse, we see the multigenerational learned behaviors that involve spouse abuse and sexual abuse. As we as individuals evolve developmentally, we establish our relationships based upon our past experiences. This occurs both within and outside of the home. Our dating and spousal relationships come out of our pasts. In terms of parenting, we may not only wind up raising our children, but often we may also be "raising" our parents or other family members. Any one of these relationships could potentially involve a chronic or debilitating illness resulting in total care responsibilities. These heavy responsibilities can result in frustration and subsequently, neglect or abuse—be it emotional or physical.

As I continued my re-thinking, it became clear that it's not just in our professional roles that we deal with violence. It's a part of us every time we turn on the television, listen to the radio, read a newspaper or walk outside our doors. Additionally, for many of us, it's a part of our own home or daily life experience. It is me and we and not somebody else.

In our society there are many attitudes that continue making violence a problem. We're part of a society that doesn't like to think. Everybody wants a quick fix—"Just tell me what to do." Now, if I dislike what you tell me, then I'll go ask someone else or perhaps I'll decide to ask several someone elses. This is to say that we've become a society that doesn't put much energy into problem solving. We've become too impatient to worry. Think of the times you've heard people say that they tried to think about their problems, but that it made them too confused. They then proceed to tell you that they didn't want to worry anymore because the worrying was not good for them. For those who have moved beyond that point and are ready to take action, I'd advise you to succeed with your first try. After the first try, the presumption is that you're not serious.

Whatever you do, **don't** add sex to the equation. If it's a spousal situation, society says it's a private matter, so don't get in-

volved—it's nobody else's business. We know what happens based on the Anita Hill/ Clarence Thomas experience. The hearing solicited lots of opinions associated with blame or finding fault, and it was a situation involving sexual issues without violence. In dating situations, our examples are the William Kennedy Smith and Mike Tyson sagas. Society viewed both incidents by saying that if you place yourself in, or find yourself in, an unsafe situation, you deserve whatever happens to you since you brought it on yourself by not being more careful. Increases in substance abuse and the violent behaviors associated with it are factors with this cycle. Society's attitudes weigh heavily as to whether the alleged victim is ever perceived as a victim. Society also tends to believe that the perpetrator's actions are beyond control and that he is unable to resist temptations. If tempting circumstances exist, the inappropriate responses are justified.

We, as members of society, must get involved on any and every level that we can. We tend not to ask sometimes when we see the subtle, or even the obvious, signs of violence. We cannot continue to do this! We tend to want a quick fix in resolving the problem of violence, and we tend to fight violence with violence. To expect that long-term problems can be solved in a short period of time is as unrealistic as hoping that the violence issue will be resolved on its own without intervention. What we've got to do is to work individually, as families, collectively in groups, financially and legislatively to become strategists who advocate for problem-solving to obtain basic human rights when it comes to violence. The larger challenge is to develop methods for empowering those involved in violence in order to stop its perpetuation. The key point to remember is that it will be a continuing process, but that the power to make it happen is within each one of us. Please use it as often and as wisely as you can, and never minimize the effort or impact you may make. We need to wake up to the impact violence has made, whether the examples have been large or small. We need to WAKE UP!

Focus Group Reports

Background

Fifteen focus groups met during the Forum to discuss each major track topic from the perspectives of (1) ethnic or racial influence; (2) the life cycle of the woman from menarche (onset of menstruation) through young adulthood, midlife, maturity and the elderly years; and (3) interagency linkages or systems challenges. Three focus groups addressed each one of the five track topics from the standpoint of one of these perspectives. The focus group reports follow.

FOCUS GROUP I—RACIAL OR ETHNIC INFLUENCES

Problem

The deliberate institutionalization of racism, poverty and sexism which are held together by violence

Interventions

1. To foster and encourage the critical role of women in initiating change
2. To educate in the broadest sense by naming the issues (racism, classism and sexism) openly and consistently on both personal and public levels
3. To give focus and attention to the internal issues of women; to build ego strengths in ways sensitive to the various cultures
4. To re-establish "the community" (in whatever cultural context is relevant) as the holder of shared values
5. To name the double standard (as it applies to class, race and gender) as it is played out in the United States
6. To educate each other about the realities of poverty, racism, sexism (from culture to culture, class to class)

Barriers

1. Resistance of those in power (the dominant society)
2. The "patriarchal" systems
3. The oppression of federal/state bureaucracies upon those they serve
4. Fear of personal risk
5. Fear of public risks (to career, reputation, etc.)

6. Lack of leadership committed to addressing issues
7. Lack of vehicles by which to pass on community values
8. Limits on personal time, energy, mental space among service providers
9. General consensus that women have no internal needs

Recommendations

1. Creating a strong network of advocacy groups and agencies
2. Encouraging women to move into decision-making positions and to engage in political activities
3. Creating an atmosphere of inclusiveness in all stages of planning and decision-making processes

FOCUS GROUP II—WOMEN'S LIFE CYCLE

Brainstorming

Perceptions of violence by women of color by life cycle:

1. Age is a continuum
2. Domestic violence includes assault—physical, verbal, spiritual, emotional
3. Unspoken behaviors
4. A desensitized media plays up social demoralization
5. Violence is dynamic and progressive
6. Lack of awareness
7. Violence as a learned behavior and disease used for power and control
8. Denial of problems
9. Devaluation
10. Policy differences needing standardization
11. Fear of reality—no support, no job skills, etc.
12. Lack of communication
13. Lack of channels through which to ventilate anger
14. Lack of victim support for women and children

15. The influence of alcohol and drugs
16. Teen dating violence
17. Co-dependency
18. Lack of role models
19. Physical and medical effects
20. School problems
21. Hunger
22. Low productivity
23. Youngsters taking on a parenting role
24. Lack of education in parenting
25. The impact of abuse
26. The problem is getting worse.
27. Keeping the problem in the closet—reluctance to report
28. Financial concerns
    a. Family
    b. Underfunded programs
    c. Lack of support
29. Band-aids and lip service for the problem
30. Need to get at problem from the individual level
31. Lack of cultural sensitivity
32. Language differences
33. Lack of cultural values and beliefs in the educational system —Anglo dominated
34. Teen pregnancy—role of boyfriend—distorted family concepts
35. Babies abused by boyfriends
36. Extended family providing the parenting
37. Need for teen pregnancy prevention
38. Disrespect of the elderly by the family
39. Isolation of the elderly
40. Physical abuse

Violence

Problem

The dynamic cycle of domestic violence

Prevention

1. Education—early and continuous
   a. Prenatal
   b. Head Start and the school system
   c. Community
2. Parent involvement
   a. Serve food
   b. Provide child care

Interventions

1. National law for rehabilitation using the alcohol model of outreach, job (employee assistance) approach
2. Promote awareness in communities
   a. Use celebrities
   b. Use national models and experts
   c. Contact resources
   d. Establish coalitions at the community, state, national levels
   e. Establish information network—assess funds which might be available and identify effective interventions
3. National Association of Domestic Violence—model programs

Barriers

1. Racism and prejudice
2. Funding
3. Understanding and awareness of the disease
4. No standards
5. Hidden social problems
6. Lack of cooperation and communication among the individual, local, state, and federal levels—law and order
7. Policy differences—need model policies

Recommendations

1. Awareness
2. Lifestyle changes—restructuring
3. Education—schools

4. Need motivation to make changes
5. Need mandatory sentencing for first, second and third offenses
6. Need standard laws
7. Need to evaluate effectiveness of programs
8. Recognition that the disease is a lifetime one and ongoing
9. Need federal and state resources
10. Counseling
11. Need for local programs
    - a. Prevention
        1. Family
        2. Human services
        3. Law enforcement
        4. Assessment of needs
    - b. Choices
    - c. Active leadership and participation
        1. School boards, e.g.
        2. Political positions
    - d. Utilization of the media
        1. City councils should enforce TV program standards
        2. Need positive media programs
    - e. Utilization of community resources, e.g., women activists to promote awareness
    - f. Student employment
    - g. Other employment opportunities
    - h. Summer activities
    - i. System whereby the "drug-using" father can stay at home
    - j. Need resources for the prevention and control of crime
        1. Fines
        2. Federal and state involvement
        3. Lobbying of the legislature
    - k. Need information on model programs of excellence
    - l. Need defining of the role of men—displacement a problem
    - m. Need maintenance programs
    - n. Need to target high-risk populations
    - o. Build incentives for high-risk youngsters

p. Begin early (with Head Start) to proactively develop acceptance to youngsters needing help—teach positive behaviors—overcome stereotypes
   1. drugs
   2. conflict resolution
   3. positive role models and affirmation

FOCUS GROUP III—INTERAGENCY LINKAGES OR SYSTEMS CHALLENGES

Problem

Unavailable and inefficient service linkages

Barriers

1. Lack of funding
2. Geographical distances
3. Myths surrounding family violence
4. Politics
5. Sexism
6. Racism
7. Low self-esteem
8. Violence as a conditioning behavior
9. Poverty
10. Lack of adequate housing—homelessness
11. Criminal justice and legal systems

Interventions

1. Hold statewide symposiums at which recommendations and plans of action are developed.
2. Make recommendations and submit them to appropriate and relevant government or other official offices.
3. Develop an office of minority health which will address women's issues.
4. Involve federal, state, and local politicians and officials in
   a. Obtaining funding for programs
   b. Enactment of legislation
   c. Alternatives to sentencing
   d. Educational support and training

5. Name an organization which will take the responsibility to ensure that the above recommendations are carried out.
6. Empower local community-based organizations.

Violence Track Report

The track group which examined the issue of violence as it impacts women of color determined that the major problems include the unavailable and inefficient service linkages which lead in turn to the dynamic cycle of domestic violence. This cycle results in the deliberate institutionalization of racism, poverty and sexism, which are held together by violence.

Recommendations for resolving these problems were presented by the track group.

1. Standardized national laws and policies are needed which include rehabilitation and which use the alcohol model, outreach and employee assistance approaches.

2. Networking by women is important. The creation of a strong network of groups and agencies which can advocate for women is a critical need. Women need to become informed about the issues surrounding violence and to then move into decision-making positions and engage in political activities.

3. Statewide actions required are a coalition of groups organized to bring about change; statewide symposiums on the subject; and a central or local office of minority health which looks at women's issues.

4. Early and continuous education can bring about awareness of the problem. This should be included in prenatal care of the mother, in Head Start and the school system, and in the community. Community education should use celebrities, national models and experts, and an information network of model programs should be established.

5. Since the community is the holder of shared values, each community must define for itself the prevention and intervention techniques which will work best for its population.

Opening Ceremonies

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Reproductive Health & Minority Women

Background Paper

"—we immediately started to look at birth, and to realize that we are women with a total reproductive cycle."
from "Breathing Life Into Ourselves: The Evolution of the National Black Women's Health Project" by Byllye E. Avery

MENSTRUATION

A woman's ability to reproduce is begun with the onset of menarche, or menstruation, at about 12 years of age (plus or minus two years either way).

- Menstrual disorders may include amenorrhea (absence of menstruation); dysmenorrhea (painful menstruation); premenstrual problems, referred to as premenstrual syndrome, or PMS (experienced by four of every five women); and iron deficiency anemia (experienced by women and some adolescents with heavy flows). (1)

REPRODUCTIVE DISORDERS

There are a number of disorders of the reproductive system which account for over 30 million visits to physicians annually. These disorders also account for 40 to 70 percent of the cases of infertility seen in women. (1)

Sexually Transmitted Diseases (STDs)

- Sexually transmitted diseases (STDs) affect women more severely than men. (1)
- Some 12 million cases of STD occur each year, and 86 percent are found in women 15 to 29 years of age. (2)

- STDs include syphilis, gonorrhea, chlamydia trachomatis infections, genital herpes, human papillomavirus, chancroid, hepatitis B, vaginitis and most recently, the human immunodeficiency virus (HIV) infection which is discussed separately below. (2)
- Complications of STDs may include pelvic inflammatory disease (PID), which may cause infertility, ectopic pregnancies, blindness, cancer, fetal and infant deaths, birth defects and mental retardation. (1,2)
- Minority and poor women tend to experience a disproportionate share of STDs:
  - Blacks (male and female) had 1,990 cases of gonorrhea per 100,000 population in 1989, compared to 114 cases per 100,000 in the total population. (2)
  - Blacks experienced 118 cases of syphilis in 1989 compared to 18.1 for the total population. (2)
  - STD rates are much higher for Native Americans than for the general population. (3)

Other Disorders

- Urinary tract infections affect one in five women. (1)
- Toxic shock syndrome (TSS), thought to be associated with tampon use, affects three to fourteen of every 100,000 menstruating women each year, but seems to be declining. (1)
- Cancers of the cervix, ovaries and uterus also affect women's reproductive health. (See background paper on Chronic Disease.)

HIV Infection

> "AIDS is not a disease of women, nor children, nor men, but a disease of families."
>
> Antonia C. Novello, M.D., M.P.H.,
> U.S. Surgeon General

- Of 214,609 people in the U.S. diagnosed with full-blown AIDS as of March 1992, 22,607, or 10.5 percent, were women. (4)

- In 1990, the largest rate of increase in AIDS cases was among women and adolescents. AIDS is the fifth leading cause of premature death among women. (5)

Minority Women

- Minority women tend to experience a greater share of the HIV/AIDS problem, as can be seen in the following table.

Reported Adult/Adolescent AIDS Cases—Number and Percent
March 1992

	Whites	Blacks	Hispan.	Asian	Nat.Am.
Total cases	115,760	61,970	34,679	1,346	343
Percentages	53.9%	28.9%	16.1%	.6%	.1%
Female cases	5,833	11,931	4,628	111	50
Percentages	25.8%	52.8%	20.5%	.5%	.2%

Source: "AIDS/HIV Surveillance Report," Centers for Disease Control, April 1992.

5

As can be seen, minority females account for greater percentages of AIDS cases than do all minority groups of total cases.

—Black Women

- Fifty-five percent of Black female AIDS cases are due to intravenous drug use, with 34 percent of cases caused by heterosexual contact. (4)
- Black (and Hispanic) teens are more at risk of HIV infection than adults through heterosexual contact (53 percent versus 38 percent in 1987). (6)

—Hispanic Women

- Subgroups of Hispanic women have differing rates of AIDS/HIV infection; however, these breakdowns are not available. (7)
- The Hispanic teen is at high risk for HIV infection (see Black Women above).

- Fifty percent of AIDS cases in Hispanic women are due to intravenous drug use, with 39 percent of cases due to heterosexual contact. (4)

—Asian/Pacific Island Women

- The major mode of transmission for Asian/Pacific Island women is heterosexual contact (34 percent of cases), with only 15 percent of cases due to intravenous drug use. (4)
- While reported numbers are low for these women, they are highly at risk for infection through heterosexual contacts. (8)
- The largest Asian population to be affected by AIDS is the Filipino subgroup, followed in order by the Japanese, Chinese and Vietnamese. (9)
- As of February 1992, Asians had the largest percentage increase in newly diagnosed AIDS cases. (7)

—Native American Women

- Fifty-eight percent of AIDS cases among Native American women are the result of intravenous drug use, with 20 percent caused by heterosexual contact. (4)
- Because of the small numbers of cases of AIDS among these women, resources for prevention and care are scarce. (7)

—Other Female Subgroups

- One of every 500 college students is HIV-infected. (6)
- Although adolescents aged 13 to 19 represent less than one percent of the reported AIDS cases, their numbers are doubling every year. (6)
- In 1989, as many as 10 percent of reported AIDS cases were among individuals 50 years of age and older. The major risk factor for this population is homo- or bi-sexual activity, and the second is blood transfusions. (10)
- Minority women and their children who are homeless are at great risk for AIDS—educational materials for the low income and poorly educated are limited, and health care resources are not designed to provide AIDS care for this population. Illegal drug use and sex partners who use illegal drugs are major risk factors for these women. (11)

FAMILY PLANNING

"To be all that we can be—even if we join the Army—we must control the timing and circumstances of motherhood."
by Judy Simmons in *The Black Woman's Health Book*

Unintended Pregnancies

- In 1988 American women reported that 56 percent of their pregnancies during the previous year were unintended. (2)
- In 1982, of Black women's wanted births, 10.2 percent were low birth weight; of unintended births, 13.6 percent were low birth weight. (2)
- When pregnancies are planned, women tend to seek prenatal care earlier than if not planned.
- In 1985 Black adolescent female pregnancy rates were 186 per 1,000 females; Hispanic rates were 158 per 1,000 females; and rates for all adolescent females 15 to 19 were 110. There is an assumption that the majority of pregnancies in this group were unplanned. (2)
- Teens account for about one-third of unintended pregnancies. (2)
- In Region VIII in 1991, 120,482 women utilized federally funded family planning clinics. Of these, 98,675, or 86 percent, were below 150 percent of poverty. (12)

Infertility

- Infertility affects an estimated 2.4 million married couples plus an additional number of unmarried couples and singles. (2)
- Hispanic women have higher rates of infertility than non-Hispanic women (6.5 percent versus 4.3 percent). (2)

CHILDBEARING

"Infant mortality is not a medical problem; it's a social problem."
from "Breathing Life Into Ourselves: The Evolution of the National Black Women's Health Project" by Byllye Y. Avery

- Childbirth is increasingly being perceived as a natural experience of women, and birthing problems have greatly declined.
- While the ages for childbearing are usually defined as 15 to 44, two extremes are possible. Over-thirty rates have been rising due to women delaying starting families until their employment status is secure or for other reasons. The other extreme is the adolescent who may suffer possible physical, employment, educational and income problems due to an early unplanned pregnancy. (1,2)

Prenatal Care

Early prenatal care, starting within the first three months (trimester) of a woman's pregnancy, is considered key to optimal outcomes for both the mother and baby. Problem pregnancies may often be prevented, and such complicating disorders as diabetes, substance use and potential fetal abnormalities may be handled.

- In 1988, early prenatal care was provided in 79 percent of White live births. Early care was provided in the following percentages of live births to minority women: 86 percent of Japanese; 82 percent of Chinese; 78 percent of Filipinos; 61 percent of Blacks; and 58 percent each of Native Americans and Mexican Americans. (13)
- Data for women receiving absolutely no prenatal care in 1980 shows that 4.3 percent of White women and 8.8 percent of Black women received no such care. (1)

Infant Mortality—Low Birth Weight

Major improvements in health care provided to both the mother and child have served to reduce infant and maternal death rates substantially. Rates for minorities, however, still remain higher than those for Whites. The 1989 rate for the United States was 9.7 per 1,000 live births, the lowest rate ever. (14)

- Thousands of babies in the U.S. die in their first year, but those in minority groups have less chance of reaching their first birthday. (15)
- Prenatal care has the greatest impact on infant deaths, but minorities are less likely than Whites to receive early prenatal care. (15,16)
- Two-thirds of infant deaths are attributable to low birth weight and/or premature deaths. (1)
- Risk factors for low birth weight babies (less than 2,500 grams) include low socioeconomic status, low educational level, late prenatal care, smoking and substance abuse. (2)

- In Region VIII, both Colorado and Wyoming had 1988 low birth weight percentages which exceeded the rate for the U.S., which was 6.9. Colorado's percentage was 7.8 and Wyoming's 7.0. (14)

Black Women

- Infant mortality rates for Black babies are more than twice as high as those for White babies. (1)
- In 1987, the U.S. rate was 10.1 per 1,000 live births; for Blacks the rate was 17.9. (2)
- Black women are twice as likely to give birth prematurely and/or to experience infant or fetal death. (2)
- From 1981 to 1986 there tended to be an increase in the rate of very low birth weight babies (less than 1,500 grams) born to Blacks—a 1.6 percent increase per year. (2)
- In 1988, 13.3 percent of Black births were low birth weight births compared to 5.7 percent of White births. (13)

Hispanic Women

- Hispanics are a younger population and tend to have large families, but there is little data available on the reproductive risks to these women. (1)
- Negative factors for Hispanic women may include larger families, extremes of maternal age, late-stage prenatal care and lower socioeconomic level. (1)
- In 1983 and 1984, Mexican-American women tended to have infant mortality rates which were the same as, or slightly higher than, those for Whites (1983—9.1; 1984—8.9; Whites 1984—8.6). (2)
- Colorado statistics for 1989 show infant mortality rates of 8.5 for Whites, 13.9 for Blacks and 9.6 for Spanish surname. (14)
- Migrant females 20–29 years of age visit health clinics most often for pregnancy, diabetes and reproductive problems. (17)
- Low-birth-weight babies accounted for 5.6 percent of Mexican-American births compared to 5.7 percent of White births in 1988. (13)

Native American Women

- Native Americans have generally higher infant mortality rates—in 1987 the rate was 12.5 compared to 10.1 for the U.S. as a whole. (1)
- Despite major declines in the infant death rate, the effects of substance abuse on Native American babies is a serious problem which is still being researched. (1)
- In some tribes as many as 25 percent of births are fetal alcohol syndrome (FAS) births. (18)
- Native American mothers tend to be younger—in 1986–88, 42 percent of Indian mothers were under age 20 when they had their first child compared to 23 percent for the U.S. all races in 1987. (3)
- In 1986–88, infant mortality rates for the Aberdeen Indian Health Service area, which serves North and South Dakota, were 19.8 per 1,000 live births, the highest of the twelve IHS areas. Billings IHS, which serves Montana and Wyoming, was fourth highest at 14.6. The rate for all the IHS areas was 11.1, with the 1986 rate for the U.S. at 10.1. (19)
- In 1988, low birth weight infants were six percent of Indian births, compared to 5.7 percent of White births. (13)

Asian/Pacific Island Women

- As has been stated before, there is little information available for this population, and this includes their particular childbearing risks.
- For the years 1983 and 1984, Asian Americans had infant mortality rates of 8.4 and 8.8 per 1,000 live births. These rates compare to 8.6 for Whites in 1984. (2)
- Low birth weight percentages were 6.3 percent of Filipino births, 6.2 percent of Japanese births and 4.6 percent of Chinese births, compared to 5.7 percent of White births in 1988. (13)

Maternal Mortality

- There were only 251 total maternal deaths in 1986, but these are deaths which could have been prevented. (2)

- Black women tend to die at three times the rate of White women. In 1987 there were 14.2 deaths per 100,000 live births to Black women and 5.9 deaths for White women. (2)
- Ectopic pregnancies are the leading cause of maternal death among Black women, and it is thought that PID, gonorrhea and chlamydial infection may be the major contributors. (1)
- Despite major improvements in the Native American maternal death rate (from 82.6 deaths per 100,000 live births in 1957–59 to 8.8 deaths in 1985-87), the rates are still 22 percent higher than for the U.S. all races (7.2 per 100,000 live births in 1986). (3)

CHILDBEARING PROBLEMS

"I had ambitions as a child, but my hopes and dreams were almost killed by the burden of trying to raise a child while I was still a child myself."

Quoted in "Teenage Pregnancy: A Case for National Action" by Faye Wattleton

- In 1985 teen pregnancy rates were 110 per 1,000 women for all women. For non-White Hispanic women, the rates were 158 per 1,000 women, and for non-White women (80 percent presumed to be Black) rates were 186 per 1,000 women. (2)
- It is estimated that of the age group 15 to 17 who had babies, four percent of Hispanic, two percent of White and one percent of Black women had married. (2)
- By age 20, one-fifth of White and Hispanic 15-year-old females and one-fourth of Black females had ever experienced sexual intercourse. (20)
- Between 1988 and 1990, some two-thirds of Native American high school seniors—56.8 percent of females—reported they had sexual intercourse. The average age for first intercourse for females was 14.2 years. (21)
- In 1984, 14 percent of all mothers under age 15 delivered low birth weight babies; 16 percent of Black mothers, 11 percent of White mothers and 15 percent of mothers of other races under 15 delivered low birth weight babies. (2)
- For migrant females aged 15 to 19, pregnancy is the most frequent reason for visiting a clinic. (17)

- The problems that can be caused by teen pregnancy may include emotional and psychological disruption, social and economic effects on both the mother and child, and economic costs to society. (2)
- At risk of teen pregnancy are girls who are deprived of love from, or who may feel unaccepted by, their families. These are often girls whose parents are domineering, who are of lower income levels, who may be behind in school, and who may lack parental supervision during dating. (22)

Substance Abuse

- Many babies born to alcohol-abusing mothers may show symptoms of FAS (fetal alcohol syndrome) or FAE (fetal alcohol effects).
- Characteristics of FAS babies may include facial deformities, growth deficiencies, birth defects and mental retardation. (1,2,3)
- A 1984 survey showed that of women who drank before pregnancy, only 30 percent stopped drinking during pregnancy. (1)
- FAS surpasses Down's syndrome and spina bifida as a cause of mental retardation. (23)
- American Indians and Blacks are most impacted by FAS, with four births per thousand and .8 births per thousand, respectively. (The baseline is shown as .22 per thousand births). (2)
- From 1981 to 1986, FAS rates among American Indians and Blacks were 33 and 7 times higher, respectively, than among Whites. (2)
- It is estimated that two to three percent of all birth defects are caused by chemicals or by drugs (illegal or prescription). (23)
- Although more research is needed on the effects of drug abuse on childbearing, it is known that these babies must experience withdrawal after birth and may be of low birth weight, may be born prematurely, or may have neurological disorders. (1,2,3)
- Cigarette smoking is known to cause babies to be smaller in size and lighter in weight and may cause prematurity, miscarriage, stillbirth or death. Babies of mothers who smoke also are more at risk of illness or death during their first year. (1,2,3)

High Risk Pregnancies

- Certain conditions in women can place the baby at risk of prematurity or low birth weight, including the above abuse of substances, very young mothers (under the age of 15), poor nutrition, poor health status, and previous problems with childbirth. (1)
- Diabetes may develop during pregnancy (known as gestational diabetes) and cause complications for the baby if insulin levels are not carefully monitored and controlled. (24)
- One in 20 women will develop toxemia or preeclampsia, which can lead to death. (1)

Violence

- One in five pregnant women is battered, and although battered women are pregnant more often, they carry their babies to term less often. (Minority women are at greater risk for battering). (25)
- Low birth weight infants are born to 6.6 percent of nonbattered women, but to 12.5 percent of battered women. (26)

MENOPAUSE

- Some 20 percent of all women have severe symptoms during menopause. There is not strong evidence that depression accompanies menopause. (1)
- Estrogen replacement therapy (ERT) is often given for menopausal symptoms, but there are concerns that its use may increase the risk of breast cancer in women. On the other hand, it is thought that ERT provides protection against heart disease. (1)
- Osteoporosis, or a weakening of the bones, is common in older women and is estimated to affect about 20,000,000 Americans, particularly women. (1)
- At greater risk for osteoporosis are small-boned White and Asian women. Heredity is a factor. (27)

ISSUES

- More information is needed on reproductive problems of minority women, and particularly the causes of their higher infant and maternal death rates and those other disorders which impact minority women more severely.
- Research is lacking in how to change harmful behaviors in minority women so that high-risk behaviors are reduced.

References

1. *Women's Health: Report of the Task Force on Women's Health Issues, Volume II.* U.S. Department of Health and Human Services, Public Health Service, 1987, pages II.5–20; II.86; II.37–47.

2. *Healthy People 2000.* U.S. Department of Health and Human Services, pages 189–195; 365–380; 496–506.

3. "Indian Women's Health Care: Consensus Statement." United States Department of Health and Human Services, Public Health Service, Indian Health Service, January 1991, pages 10–13.

4. "Adult/Adolescent AIDS Cases by Sex, Exposure Category and Race/Ethnicity, Reported Through March 1992." U.S. HIV/AIDS Surveillance Report, Centers for Disease Control, April 1992.

5. "Women and HIV: A Prognosis." Fact Sheet (no source provided).

6. *Preventing HIV Infection Among Youth: OSAP Technical Report 5.* U.S. Department of Health and Human Services, Public Health Service, Alcohol, Drug and Mental Health Administration, Office of Substance Abuse Prevention, 1991.

7. *The Impact of HIV on Communities of Color: A Blueprint for the Nineties.* National Minority AIDS Council, March 1992.

8. Willy Wilkinson. "Asian/Pacific Island Women and HIV: The Risk is Real." In *FOCUS,* Asian American Health Forum, Inc., Spring/Summer 1992.

9. Dao, Eliane, A.R.N.P. "HIV Prevention and the Asian Community." In *Region X: Proceedings of Women's Health Issues Conference, Women's Health Issues.* Seattle, Washington: U.S. Public Health Service, March, 1992.

10. "Age Page: AIDS and Older Adults." National Institute on Aging, U.S. Department of Health and Human Services, Public Health Service, National Institutes of Health, 1989.

11. Williams, Scott and Troup. "AIDS Education and Risk Reduction for Homeless Women and Children: Implications for Health Education." In *Health Education,* Association for the Advancement of Health Education, December 1989, pages 44–47.

12. Family Health Branch, U.S. Department of Health and Human Services, Public Health Service, Region VIII, 1992.

13. *Health United States 1990.* U.S. Department of Health and Human Services, Public Health Service, pages 9–11.

14. *Colorado Vital Statistics, 1989.* Colorado Department of Health, July 1991.

15. *Closing the Gap: Infant Mortality, Low Birthweight and Minorities.* U.S. Department of Health and Human Services, Public Health Service, Office of Minority Health, 1988.

16. "Infant Deaths Lowest Ever in U.S." In *The Denver Post*, Denver, Colorado, February 1992.

17. Dever, G.E. Alan, Ph.D. *Migrant Health Status: Profile of a Population With Complex Health Problems.* Migrant Clinicians Network Monograph Series. Austin, Texas: National Migrant Resource Program, Inc., 1991.

18. Asetoyer, Charon, M.A., M.I.A. "Fetal Alcohol Syndrome; A Global Issue." In *Region X: Proceedings of Women's Health Issues Conference, Women's Health Issues.* Seattle, Washington: U.S. Public Health Service, March 1992, pages 47–52.

19. *Regional Differences in Indian Health.* U.S. Department of Health and Human Services, Public Health Service, Indian Health Service, 1991, page 24.

20. *The Health of America's Youth.* National Center for Education in Maternal and Child Health.

21. Blum, Robert, M.D., Ph.D., and Resnick, Michael D., Ph.D. *The State of Native American Youth Health.* Minneapolis, Minnesota: University of Minnesota, March 1992.

22. Liburd, Leandris C., and Bowie, Janice V. "Intentional Teenage Pregnancy: A Community Diagnosis and Action Plan." In *Health Education*, Association for the Advancement of Health Education, December 1989, pages 33–38.

23. Zamula, Evelyn. "Drugs and Pregnancy: Often the Two Don't Mix." In *FDA Consumer Magazine*, June 1989.

24. Oja, Janet, R.N.C., M.S. "Diabetes and Pregnancy." Presentation for Seminar, Women's Health Issues, Centennial Area Health Education Center, Greeley, Colorado, January 16, 1992.

25. Gaines, Kathy, R.N., B.S.N. Presentation for Seminar, Women's Health Issues, Centennial Area Health Education Center, Greeley, Colorado, January 16, 1992.

26. *Violence and Victimization: An Annotated Bibliography.* Bethesda, Maryland: Nova Research Company for the National Institute on Drug Abuse, September 1991, pages 15–69.

27. Papazian, Ruth. "Osteoporosis Treatment Advances." In *Current Issues in Women's Health.* FDA Consumer Special Report, U.S. Department of Health and Human Services, Public Health Service, Food and Drug Administration, November 1991.

Note: Quotes from articles attributed to Byllye E. Avery and Judy Simmons are from *The Black Women's Health Book: Speaking for Ourselves.* Evelyn C. White, Editor. Seattle, Washington: The Seal Press, 1990.

Panel Presentation

Reproductive Health and Minority Women

Margueritte White, M.D.

The field of obstetrics and gynecology is central not only to women's reproductive health, but to their total health. In most instances, the gynecologist (or obstetrician) serves as the woman's primary caretaker, since often he/she is the only physician frequented by many women with any kind of regularity. This places these physicians in an excellent position to render total care to their patients. What exactly does this mean? For the obstetrician, ideally this encompasses the following:

A. Pre-conception: This is an excellent time to ascertain a woman's health and define risks associated with medical conditions that could make pregnancy a high risk for both mother and fetus. There are some conditions, e.g., certain heart diseases or pulmonary hypertension, which carry a high likelihood of mortality for the mother. Other conditions would simply require fine-tuned control (diabetes, for instance), a change in medications (some seizure disorders) or simply close observation during pregnancy.

B. Antenatal: This is the classic notion of prenatal care. Under ideal circumstances, the mother is followed for close to nine months. Even if there are no underlying complications, there are many women and babies who will develop problems during gestation (intrauterine growth retardation, pre-eclampsia, to name a few) that, when detected early, can be managed successfully.

C. Intrapartum: This refers to care during labor. If a woman has gotten through systems A and B, special management can be addressed early and planned for, thereby decreasing the likelihood of an unforeseen catastrophe such as an eclamptic seizure.

D. Postpartum: This refers not only to the period immediately after delivery but includes a visit six to eight weeks after birth, depending on the mode of delivery (caesarean section or vaginal). This again allows for evaluation of the woman's baseline health (occasionally pregnancy may unmask a medical condition such as diabetes or hypertension). It also allows for discussion of contraception, as well as parenting issues and stress.

The gynecologist's role involves delivering comprehensive reproductive health for all women from childhood to late adulthood. Pediatric gynecology is a rapidly developing field that not only focuses on congenital malformations and endocrine disorders of adolescents, but is increasingly adding knowledge and practice to the field of sexual abuse and management of sexually transmitted diseases in both prepubertal and pubertal girls. The older woman not only faces issues of menopause and hormonal replacement therapy and its relationship to breast cancer and cardiovascular disease, but needs to be increasingly educated about alternative treatments for urogynecologic problems, such as urinary stress incontinence and uterine or vaginal prolapse. Of course, between either

end of the spectrum lies a myriad of gynecologic conditions requiring surgical and/or medical management. Some of these, such as pelvic inflammatory disease, have far-reaching consequences beyond the immediate stigma, discomfort, pain and cost of hospitalization and treatment. Common sequelae include ectopic pregnancy—the leading cause of maternal mortality in the first three months of pregnancy—infertility, chronic gynecologic pain and tubo-ovarian abscesses. Detection, prevention and treatment of gynecologic malignancies such as cervical, ovarian and uterine cancer are of utmost priority (as well as the childhood gynecologic malignancies). Cervical cancer is a preventable disease. Uterine cancer can often be detected early, thereby maximizing chances for complete cure. Though ovarian cancer is often detected late, regular routine examinations increase one's chances of being diagnosed at an early stage. Additionally, knowledge of a prior family history may allow for special screening and intervention.

How then has this concept affected the reproductive health of women of color? In many ethnic groups, the incidence of low birth weight babies, premature deliveries, perinatal and neonatal death is nearly twice that of the general population. Sexually transmitted diseases, most alarmingly syphilis and human immunodeficiency virus (HIV), are rising—a particularly frightening phenomenon in view of the fetal and neonatal effects of these disorders. Many malignancies are detected at a later time when the chance for cure is dramatically reduced. In many situations, the obstetrician (and gynecologist) is placed in a position of reacting at a point in time when the greatest damage has already been done. When a woman with a growth-retarded fetus presents in premature labor and must undergo a caesarean section for fetal distress, it is already too late. When a fourteen-year-old, herself a victim of sexual abuse and neglect, is found to have cervical cancer, there is a sense of bitterness and failure.

How then to turn things around? Early care and intervention are clearly a desirable goal. The key is that this must be a mutually agreed-upon and sought-after goal by both caregiver and care-receiver. There must be availability, accessibility and utilization of services. Many of the behaviors that place women at risk for poor outcomes for themselves and their unborn children are the behaviors that prevent them from accessing care. I contend that these behaviors are deeply rooted in a mental focus and belief system so deeply entrenched in the psyche that jeopardizing the immediate and long-term welfare of the baby becomes an acceptable risk. There can be no physical or behavioral change without first a mental change. All parties must commit to creating this change. A woman with a sense of self-esteem, purpose, direction and self-respect is more likely to come in for prenatal and gynecologic health care. Once this cycle begins, outcomes will improve.

In conclusion, obstetrical and gynecologic outcomes are poorer for women of color and their children in this country. Good outcomes are directly linked to access and utilization of health care services. Poor outcomes are linked to behavior patterns that are more likely to prevent use of health services. These behavior patterns in turn are rooted in belief systems that must be identified, dismantled and restructured to ensure significant behavioral changes. The obstetrician/gynecologist must become an active participant in this mental process, even while treating the physical consequences which are only symptoms. The woman at risk, of course, is the other half of the equation and must be engaged and committed to the process.

Focus Group Reports

Background

Fifteen focus groups met during the Forum to discuss each major track topic from the perspectives of (1) ethnic or racial influence; (2) the life cycle of the woman from menarche (onset of menstruation) through young adulthood, midlife, maturity and the elderly years; and (3) interagency linkages or systems challenges. Three focus groups addressed each one of the five track topics from the standpoint of one of these perspectives. The focus group reports follow.

FOCUS GROUP I—RACIAL OR ETHNIC INFLUENCES

Adolescent access to reproductive health care services which are culturally sensitive and unquestionably competent

Problem

1. Collaboration with schools and other forums (e.g., detention centers)
   - a. School exams
   - b. Physicals
   - c. Healthy lifestyle presentations
   - d. Begin with elementary school

2. Parenting education
   - a. Workshops
   - b. Churches, mosques, temples: using ceremonies, other school-related activities
   - c. Use materials and approaches which are appropriate for literacy levels

3. Community involvement in identifying and recognizing problems
   - a. Needs assessments
   - b. Capacity assessments
   - c. Adolescent focus groups

4. Education of providers and other professionals
   - a. Publicize the availability of documents
   - b. Develop awareness of culturally sensitive health care services which include respect for the patient
   - c. Specifically for those working with the adolescent population:
     1. Values clarification for self and others
     2. Belief systems

Interventions

1. Mall-based clinics with confidential services
2. Anonymous van service
3. Teen clinics
   a. Cultural-specific clinics for adolescents (e.g., Navajo)
   b. School-based clinics
   c. Special hours which are favorable for teens
   d. Discreet distribution of contraceptives
   e. Deferred medical exams
   f. Peer programs, including policy involvement
   g. Ethnic community celebrations
   h. Public service announcements geared to adolescents
   i. Education of media personalities
   j. Empowerment activities
   k. Support groups
   l. Organizational linkages
   m. Case management
   n. Incentive programs
   o. Female providers, but options for gender of the provider

Barriers

1. Funding for programs
2. Attitudes
3. Cost of services
4. Political and religious factions
5. Personal comfort and/or discomfort with the topic
6. Lack of information and misconceptions, often influenced by the media
7. Lack of appropriate role models
8. Poverty
9. Lack of transportation
10. Availability of services
11. Federal and state red tape and regulations
12. Language barriers
13. Federal and state laws
14. Inability to accommodate those with disabilities

15. Lack of ethnically diverse minority providers
16. Undocumented status
17. Denial and fear
18. System failures
    a. Lack of point of entry
    b. Lack of information regarding the system
    c. Fragmented and non-integrated services
19. Lack of political leadership—apathy
20. Homelessness
21. Peer pressure
22. Low self-esteem
23. Low literacy levels
24. Intergenerational acculturation conflicts

FOCUS GROUP II—WOMEN'S LIFE CYCLE

Brainstorming

Systems issues - access to care

1. Financial barriers
2. Cultural barriers—language differences
    a. Cultural beliefs and traditions
    b. Different sub-groups of Hispanics, Native Americans: system does not differentiate among the varying minority/ethnic cultures
    c. Translation problems
    d. Literacy issues
    e. Need to plan services for different subcultures and need to collect data by different subcultures
3. Need for women of color in leadership positions
    a. Keep leaders in touch with community needs
    b. Maintain cultural sensitivity for all ethnic subgroups
4. Bureaucratic red tape
5. Reproductive choice
    a. Discrimination against women—lack of equal access to effective contraception and problems with contraceptive technology

6. Welfare and health care reform are needed—the general public needs to be educated about the realities of public assistance
7. Lack of services (e.g., in Wyoming)
8. Attitudes toward minority underclass women

Specific Health Issues

1. Teenage pregnancies—marital status—intended/unintended
   a. Relationship between pregnancy and education
   b. Allowing teen access to education despite pregnancy status
2. Sexually transmitted diseases—chlamydia and fertility
   a. HPV—adolescents and treatment without parent consent
   b. HIV
3. Mental health and reproductive health
   a. Role in unintended pregnancy, teen pregnancy
   b. Sexual abuse and teen pregnancy
4. Female empowerment and assertiveness
   a. Role in preventing unwanted pregnancy (teens and others)
   b. Domestic violence (cultural violence)
5. Sex education
   a. The role of culture
   b. Cultural attitudes toward sex
6. Role of education and problems of illiteracy
7. Gay and lesbian issues—in teens this relates to suicide and teen pregnancies (to hide lesbianism)
8. Young males and contraception—taking responsibility
9. Abuse of technology—increased number of cesarean births
10. Tracking problems, e.g., follow-up and tracking after discharge from hospital
11. Breastfeeding
    a. Encourage low-income and minority women to breastfeed

b. Explore issues around breastfeeding by HIV positive women or women at high risk for HIV
c. The need for provider education

12. Occupational hazards and their impact on reproduction
13. Prenatal care and all the associated issues—cultural issues
14. Nutrition
    a. Adolescents
    b. Relationship to cancers in later life
15. Menopause

Problems

1. Lack of gender and cultural sensitivity and empowerment with regard to reproductive health issues
2. The need for more women and women of color who are culturally sensitive in leadership and policy positions
3. Lifecycle stages
    a. 12–19
        1. Empower young women—mentors—encourage them to enter health and education fields and become leaders
        2. Empower young men to let go, liberate, become leaders
        3. School-based education
    b. 20–44
        1. Encourage more preventive care for adult women (e.g., family planning)
        2. Systemic changes to support combining careers and parenting
        3. FAMILY LEAVE POLICIES and LEGISLATION
        4. Enlist parents to teach children about women's issues and sex education
    c. 45–59
        1. Reduce and/or eliminate age discrimination and cultural barriers to women taking leadership roles
    d. Over 60
        1. Age discrimination—need for services to address chronic disease and disability

2. Attention to family leave and care issues—need to decrease the burdens of child care of grandchildren

4. Violence, sexual harassment and abuse

5. Need to build and support community coalitions and to vote

6. Need to educate policy makers regarding gender and cultural issues

7. Lack of empowerment and its impact on reproductive health choices and outcomes

Intervention

Education throughout the lifecycle including improvements in basic education

—Barriers

1. Money
2. Religious groups
3. Attitudes
4. Developing alternative educational systems for illiterate and low literacy groups

—Interventions by life cycle

1. 0–19
   a. School-based, media-based, public education system
   b. Education for out-of-school youths
   c. Parent education, parenting education
   d. Religion and churches
   e. Organized activities for children—alternatives to television
   f. Peer programs
   g. All programs to be culturally relevant and sensitive
   h. Role models and mentoring programs
   i. Job training and placement and career counseling covering a full range of choices and options

2. 20–44
   a. Use of existing systems to advance (e.g., child care and on-the-job training in the welfare system)
   b. Elimination of systemic problems that promote dependency
   c. Educate women that they can change
   d. Challenge providers to discover patient histories of drug abuse, sexual abuse, domestic violence, etc.
   e. Training for providers in the above
   f. School-based education focusing on parents
   g. Support groups
   h. Mentor programs

3. 45–59
   a. Education in order to counter the myths about menopause
   b. Education about lifecycle changes
   c. Screening programs for chronic disease
   d. Culturally sensitive health promotion activities
   e. Peer group issues
   f. Programs for the displaced homemaker
   g. Issues relating to women whose children are grown and who have lost their role or women who have taken on a prematurely older role
   h. Employment and career issues for women on Medicaid
   i. Women learning to take care of themselves

4. Over 69 (includes many of same points as in the 45–59 group)
   a. Elders and sexual activity

FOCUS GROUP III—INTERAGENCY LINKAGES OR SYSTEMS CHALLENGES

Problem Identification

1. Money for additional staff, additional clinics, equipment
2. Access
3. How to stop or minimize the overlapping and duplication of services
4. Fragmented care

5. Transportation and the proximity of services
6. Quality of care
7. Time constraints
8. Medical model approach—need to adopt and adapt a multiple perspective approach

Problem: Access to Care

Access Barriers:

1. Competition for limited sources and resources
2. Lack of cooperation between local health departments, county health departments, state health departments, community health centers and the private sector
3. Lack of, or poor, communication
4. Cultural insensitivity, prejudice, stereotyping
5. Shortage of practitioners and clinicians
6. Sources of payment for care are inadequate.
7. Deficiencies in the quality of care
8. Proximity to services (weather, transportation and distance)
9. Lack of community awareness of health problems and/or barriers to accessing care
10. Backlash—blame the victims
11. Legislative backlash
12. Hours of service availability
13. Inadequate or non-existent child care
14. Inadequate or non-existent support services
15. Not placing a value on preventive services
16. Inadequate educational efforts
17. Lack of awareness of regional diversity (rural versus urban)
18. Value systems

Interventions

1. Assure availability of women care providers—diverse age and cultural backgrounds for staff
2. Use of midlevel practitioners
3. Expanded hours of service
4. Preventive care as a priority
5. Emphasis on health promotion
6. More culturally relevant outreach
7. Culturally sensitive providers
8. Adapt care delivery system to diverse needs of populations
9. Sensitivity to sexually diverse orientation
10. Make available low-literacy and/or language-appropriate education materials
11. Establish support groups and use the political process to change consumer attitudes and expectations of the care-giving system
12. Use alternative sites and facilities as points of service delivery (schools, e.g.)
13. Assess client needs and follow through on implementation
14. Better cooperative delivery of services across agencies
15. Establish active and valid coalitions consisting of all players in the health care delivery system
16. Educational interventions for health care providers, including midlevel practitioners
17. Active recruitment and training for midlevel practitioners across all levels from community to federal
18. Access to ongoing continuing education for health care providers, integrated and/or cooperative training opportunities
19. Women mentoring women to facilitate achievement of power (political, personal, professional)

Barriers to Interventions

1. Political climate
2. Inadequate funding and resources

3. Balancing priorities of "have-to-do's" and "want-to-do's"
4. Barriers to attitude change are the lack of a sense of responsibility by the community for problem resolution.
5. Isolation of the individual and an emphasis on self-preservation at the expense of the community or larger group

Recommendations

1. Coalition building
2. Mentoring and one-to-one support
3. Networking and sharing to perpetuate resources and to reduce the likelihood of re-inventing the wheel
4. Fostering buy-in at the local level. The process of change needs to begin at the local level among those who are delivering services.
5. Identification of resources that can be shared and mentored

Reproductive Health Track Report

The first major problem for women of color in the areas of reproductive health include the need for adolescents to have easy access to reproductive health care. Barriers to implementation include cost, attitudes of society, denial, and religion. Secondly, women of color are not empowered to access reproductive health care which is gender and culturally sensitive. Lastly, reproductive health care services lack interagency linkages with other services in the system, contributing to fragmentation, duplication, minimal or no communication among services, which leads in turn to a lack of access to diverse and high-quality reproductive health care.

Following are the recommendations of the track group for improving reproductive health services for women of color:

1. A first step should be the provision of education to increase the numbers of reproductive health providers in the region. The use of midlevel providers may also help accomplish this goal. Existing providers should receive continuing professional education which includes training in culture- and gender-specific reproductive care.

2. Efforts must be made to remove such access barriers to the health care system as lack of transportation, cost of care, and the lack of integrated services.

3. The community needs to be involved in identifying and recognizing the problems faced by women of color. Education of consumers should include an assessment of the needs of women of color and an assessment of the capacity and capability of the existing system to respond to the needs which are identified.

4. A model reproductive health care delivery system must be developed to include prevention and health promotion orientation, public education in ethnic and cultural sensitivity, and care that is literacy and language appropriate and which promotes awareness of, and sensitivity to, the diversity in our population. Such a system must also be dynamic in order to be effective.

Opening Ceremonies

Mental Health & Minority Women

Substance Abuse & Minority Women

Violence & Minority Women

Reproductive Health & Minority Women

Chronic Disease & Minority Women 6

The Policy Process

State Recommendations

Appendix

for Asian/Pacific Islander elderly. Filipino women are more likely than non-minorities to have uncontrolled high blood pressure. (5,6,7,8)

- In 1987, 29 percent of Black females smoked (the same as the entire population aged 20 and older); 26 percent of Hispanic females are estimated to have smoked over the period 1982–84; smoking prevalence for Native American women is estimated at 28 percent. Smoking among Asian Americans varies between newly arrived and more established groups and among the different Asian cultures. By 1987, 40 percent of lower socioeconomic status youth had become regular smokers by the ages 20 through 24. (4)
- For the period 1976–80, 44 percent of Black women aged 20 and older were overweight; 39 percent of Hispanic women were overweight (1982-84); and 1984–88 estimates for different Native American tribes ranged from 29 to 75 percent (male and female). (4)

—North and South Dakota

- The Aberdeen Indian Health Service (IHS) serves Native Americans in North and South Dakota. It reports that of all deaths in 1986–1988, 24.6 percent were due to diseases of the heart (the leading cause of death) and 4.4 percent to cerebrovascular disease (for U.S. all races, 35.8 percent diseases of the heart, 7.1 percent cerebrovascular diseases). North Dakota reports a total of 867 female deaths due to heart disease with 20 of these Native American females. South Dakota reports 67 Native American deaths due to heart disease out of 81 for all races (no sex breakout). (9,10,11)

—Colorado

- Colorado had 115 deaths per 100,000 due to heart disease in 1989. For all females the rate was 78.7 per 100,000; for White/Spanish-origin females the rate was 85.8 and for Black females 138.0. For cardiovascular diseases, all females had a rate of 21.1 per 100,000, for Spanish origin females, 24.7 and for Black females, 35.8. In that same year, 176 Spanish-origin females, 92 Black females, 5 Native American females and 12 Asian females died of heart disease. (12)

Chronic Disease & Minority Women

Background Paper

HEART AND OTHER CARDIOVASCULAR DISEASES

> "I was reminded of all the years while I was growing up that my mother's blood pressure stayed near 190/100 and how short of breath she would get just walking up the six steps to our front porch, all the time insisting she was fine."
>
> from "Controlling Hypertension"
> by Pamela Sherrod (1)

- In Black women, heart disease and stroke rank first and third respectively as the **leading causes of death**; Asian women are at lower risk of dying from most cardiovascular diseases than other races, except for stroke; in Native American women, heart disease ranks first and stroke fourth. (2)
- **Risk factors** for cardiovascular and heart diseases are high blood pressure (hypertension), elevated cholesterol levels, smoking, diabetes, use of oral contraceptives, obesity, menopause, aging, genetic disposition and physical inactivity. Chronic stress, related to being a minority and a female, is thought to contribute to cardiovascular disease and hypertension. Poverty, poor nutrition, inadequate education, low motivation and self-esteem and environmental hazards may compound health problems. (3,4,5)

Issues

- Among Hispanic women, those who are Mexican-American aged 60 or older experience **hypertension** at rates higher than the national average for Blacks. Hypertension prevalence is as much as four times higher in young Black women than young White women, and 40 percent of Black women 18 years and up have high blood pressure. Hypertension is a major concern

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—Montana

- Native Americans served by the Billings Area IHS evidenced 21.5 percent of all deaths in this population due to heart disease (U.S. all races, 35.8 percent). The state reports in 1989 a total of 1,260 deaths of females due to heart and cardiovascular diseases. Of these deaths, 1.9 percent are of females other than White. (9,13)

—Utah

- The state of Utah reports deaths by race and sex, but does not break these out by cause of death. In 1988, there was a total of 4,265 female deaths due to all causes. Of these, 25 or .59 percent were Black females, 33, or .77 percent, were Native American females and 75, or 1.76 percent, were females of Spanish origin. At its statewide ethnic minority conference, held in April of 1991, Asians and Hispanics designated cardiovascular disease as their second priority health concern. Native Americans listed it as sixth, and Blacks, while not specifically naming heart disease, named hypertension and nutrition and diet as major concerns. (14)

—Wyoming

- The state provides deaths by sex and by race, but does not break these out by cause of death, and by sex and cause but does not break these out by race. Of the total 3,249 deaths in Wyoming in 1989, 1,514 were females. Whites (male and female) comprised 3,170 of the total deaths, Blacks 10, Native Americans 64, and other races or unknown 5. (The Billings IHS also provides services to Native Americans in Wyoming.) Total deaths in the state due to cardiovascular and heart diseases number 1,231.

CANCER

"Each woman responds to the crisis that cancer brings to her life out of a whole pattern, which is the design of who she is and how her life has been lived. The weave of her everyday existence is the training ground for how she handles crisis."

from "The Cancer Journals" by Audre Lorde, as quoted in "On Cancer and Conjuring" by Janis Coombs Epps (1)

Breast Cancer

- Although minority women tend to have breast cancer rates that are usually below rates for the U.S. female population, their mortality and survival rates are poorer.
- Breast cancer is the leading cause of cancer deaths among Black women. During the past ten years, more than 33,000 Black women have died of breast cancer. (15) Average rates for 1987 and 1988 show Black female incidence of breast cancer at 93.3, and White female incidence at 114.7.* But, although incidence is lower, the breast cancer mortality rate for Black women in the same period is 30.0 and 27.3 for White women. And the five-year relative survival rate was 78.2 percent for White women, but only 63.1 percent for Black women during the period 1981–87. (16)
- Among Indian women in the Aberdeen Indian Health Service area (South and North Dakota) and the Billings IHS area (Montana), breast cancer incidence rates for the period 1982–87 averaged 44.9* for Aberdeen Native American females and 38.6* Billings Native American females. These figures compare to 32.7* for all 12 IHS areas combined. Mortality rates in these two areas also exceeded those of the 12 IHS areas (17.0, 16.3 and 12.8 respectively). (17)
- While some subgroups of Asian/Pacific Islander women tend to be at low risk for breast cancer, this risk often increases when they adopt western eating habits, which are high in fat. (18)
- Eighty percent of breast cancers are found in post-menopausal women, and 45 percent of new breast cancers are detected after age 65. (19)

**per 100,000 population*

—Risk Factors

- Risk factors for breast cancer include aging, family history, post-menopausal women who are overweight, alcohol consumption, dietary fat, and use of birth control pills. Suggested risks also include estrogen therapy and chemicals in hair dyes; however, three-fourths of all breast cancers cannot be attributed to any known specific cause, and 9 of every 10 women are at risk whether or not they have the risk factors. (18)

—Issues

- Early detection and treatment are key to controlling breast cancer, and breast exams and mammographies can detect breast cancer early, but many minority women don't know this, or if they do, they think they are not at risk. Mammographies may be considered inconvenient, costly, painful or harmful, and often physicians do not suggest that women should have them. (20) Some minority women find the breast exam distasteful and do not care to have anyone, including themselves, touching their breasts.

  Medicare will pay for mammograms, but only every two years, and Medicaid coverage varies by state. As of 1990, Medicaid in North Dakota and Montana covered all eligible women; Colorado, South Dakota, Utah and Wyoming Medicaid programs covered women only if ordered by a physician. (21)

Cervical Cancer

- Six thousand American women die annually of cervical cancer, and it accounts for about three percent of all cancers in American women. (20)
- Black, Hawaiian, American Indian and Mexican American women have high incidence rates for cervical cancer, with Blacks and American Indians having lower survival rates for this cancer. (20)
- Cervical cancer is a major health problem among Native American women. The Aberdeen and Billings IHS areas had cervical cancer mortality rates in 1980–86 of 14.5* and 13.2* respectively compared to 7.8 for all twelve IHS areas and 3.3 for the U.S. (all races). Incidence rates were 23.5* (Aberdeen), 19.6* (Billings), 20.1* (all IHS areas) and 8.8* (U.S. all races). (17)

**per 100,000 population*

- Black female cervical cancer incidence rates were 15.2* in 1987–88, while those for White females were 7.5.* Mortality rates were 6.6* and 2.0* respectively. Five-year survival rates for 1981–87 were 57.4 percent for Blacks and 67.5 percent for Whites. (16) Black women are about three times more likely to develop cervical cancer and more than twice as likely to die from it than White women. (15)
- In 1986 studies, the incidence of invasive cervical cancer was found to be 7.3 times greater for women with Hispanic surnames than for those with non-Hispanic surnames. It is the third most common cancer among Hispanic women. (22)

—Risk Factors

- Aging, low income, multiple sexual partners and early onset of sexual intercourse are all considered to be associated with cervical cancer, but the precise cause is still unknown. (20)

—Issues

- Cervical cancer can be controlled if found early, and the Pap smear, if regularly performed, can detect abnormal cells and prevent unnecessary deaths. However, few minority women, in all races, are being screened. False negative smears are a problem with Pap test technology and the waiting time for follow-up exams of positives (colposcopies) can be a problem. (20) Older women often believe they are not at risk because they are past menopause.
- Medicare will cover Pap tests, but only once every three years. Medicaid (in 1990) covered all eligible persons in Montana, North Dakota and South Dakota; in Colorado, Utah and Wyoming, Medicaid covered Paps only with a physician's order. (21)

Other Cancers

- In 1986, lung cancer surpassed breast cancer as the leading cause of cancer deaths among women. (4)
- Seventy-nine percent of lung cancer cases in women are attributable to cigarette smoking. (4) Risk of smoking is influenced by tobacco advertising, family influence, peer influence, self-image and stress (women are more likely to smoke to cope with "negative affect"). The threat of gaining weight keeps many women from quitting smoking. (20)

**per 100,000 population*

- Although the age that people begin smoking has been declining, more than 3,000 U.S. teenagers become regular smokers each day. Black and White smoking rates have been declining among students, but rates are increasing among Hispanic students. Northern Plains Indians have very high smoking rates, but rates are lower for Southwestern Indians. (23)
- Colorectal cancer (cancer of the colon and rectum) occurs more often among Black women than White women. Incidence and mortality rates are higher for Black than White women, and five-year survival rates are lower for Black women. (16)
- The Aberdeen area IHS (South and North Dakota) reports a higher colorectal cancer mortality rate than all twelve IHS areas combined, but both Aberdeen and Billings IHS areas have lower mortality rates than U.S. females of all races. (17)
- Stomach cancer has a high prevalence in some subpopulations of Asian/Pacific American women. (15)
- Being overweight was found to be associated with mortality from cancers of the uterus, stomach, colon, breast and other organs. And it is suggested that diets high in fat increase the risk of breast and colon cancers. There is also some evidence that salt-cured, pickled and nitrite-cured foods may increase the risk of stomach cancer. (23)
- Black women tend to be less aware of proctoscopic exams for colon and rectum cancer. (24) Hispanic women tend to be fatalistic and believe that "it's God's will that decides whether or not you will recover from cancer" and "there's not much you can do to prevent cancer." (25) This sense of "fatalism" can also be found among Native Americans and some Asian groups, notably the Japanese.

OTHER CHRONIC DISEASES

> "My home life is not working. My old man is an alcoholic. My kids got babies. Things are not well with me. And the one thing I know I can do when I come home is cook me a pot of food and sit down in front of the TV and eat it. And you can't take that away from me until you're ready to give me something in its place."
>
> from "Breathing Life into Ourselves: The Evolution of the National Black Women's Health Project" by Byllye Y. Avery (1)

There is a greater prevalence of chronic disease among minority women than among White women. These diseases result in an overall lower life expectancy for minority women than for their White counterparts. Elderly minority women are more likely to be sick and disabled and have higher rates of chronic disease, functional impairment and activity limitation than elderly White women. (7)

Diabetes

- Diabetes is a major health problem for Black, Native American and Hispanic women and is also a problem for some Asian/Pacific Island subgroups. (26) Major complications of diabetes may include limb amputation, blindness, heart disease and stroke and kidney failure. (4)
- The prevalence of diabetes among Black women is 33 percent higher than among White women, and death rates are 35 percent higher. The rates of diabetes are 100 percent higher in elderly Black women than in elderly White women. (5,27,28)
- While diabetes ranks eightth among Native Americans as a leading cause of death (1985–1987), for Native American women it ranks fifth. It is the third most frequent reason for medical visits to the Indian Health Service and in some tribes rates may be as high as five times the rates for Whites. (29)
- Among Hispanic women, diabetes has shown a marked increase, particularly among Mexican-American women. One study has found that 10 percent of Mexican-American women 45 and older had diabetes rates almost three times that of the national rate of 3.7 percent. (5)
- The most common principal diagnosis of females in migrant health clinics is diabetes. (The clinics surveyed serve Hispanic females.) (30)

- Diabetes among elderly Native Hawaiians, Filipinos, Chinese and Koreans is sometimes double and triple rates for Whites. And Japanese people in the U.S. have more than twice the incidence of diabetes of those living in Japan (no breakouts for women). (26)

—Risk Factors

- Risk factors for diabetes include obesity, a major problem for Black, Native American and Hispanic women. Overweight is more prevalent among females than males in all except Whites. (31) Family disposition and poor diet are other risk factors.

Arthritis

- Although minorities in general do not suffer from arthritis any more than other races, it is important to note that two of every three Americans who have arthritis are women. Rheumatoid arthritis, one of the more than 100 different forms of arthritis, affects more women than men. (32,33)
- A recent study showed that patients with rheumatoid arthritis who had the lowest autonomy on the job were 36 times more likely to be disabled from their arthritis than those with the highest job autonomy. And those whose jobs were more physically demanding were six times more likely to be disabled. It stands to reason that minority and lower-income women, who typically hold jobs with less autonomy and which are more physically taxing, would be at greater risk for disabling from rheumatoid arthritis. (34)

Other Minority-Specific Diseases

—Black Women

- Black Women—Sickle cell disease affects 1 in 500 Black newborn infants. Black women over age 65 are more at risk for hypertension than any other group. (5,28)
- Systemic Lupus Erythematosus, a disease of the immune system which affects women eight to ten times as often as men, usually appears in women 18 to 45 years of age and is three times more common in Black than White women. (35,36)
- Blacks and diabetics over 65 years of age are at increased risk of glaucoma.

—Native American Women

- Native American women may also be at risk for lupus, particularly those in some North American groups. (36) Elderly Native American women may suffer such disorders as tuberculosis, pneumonia and malnutrition. And numbers of deaths from liver and kidney disease are often higher than those for Whites, often attributable to the high rates of alcoholism among Native Americans.

—Hispanic Women

- Hispanic women have extremely high rates of hypertension (see page 101).

—Asian/Pacific Island Women

- Asian/Pacific Island women suffer more from such genetic disorders as alpha- and beta-thalassemia and hemoglobin E disease, forms of anemia, and hepatitis B, an inflammation of the liver caused by a virus. (5) Some Asian groups of women are also at risk for lupus. (35)

Issues

- The majority of the chronic diseases affecting minority women can be avoided by lifestyle changes. These include improved nutritional habits, more physical activity, cessation of smoking, weight loss, and in some cases, elimination of alcohol. In other chronic diseases, early detection and treatment are key. And with such disorders as hypertension and diabetes, control of the disease is necessary to prevent worsening of the disorder or complications.
- Health education and provider counseling are needed to bring about behavioral change, but many of the traditional methods for changing behavior do not work for minorities, and research is needed to determine what does and does not work. In many cases, lack of access prevents these women from receiving appropriate health care, whether education, prevention, treatment or maintenance.
- And, most importantly, more research is needed to determine the relationship that stress in the lives of minority women has upon their physical health. Such research needs to look at discrimination, unemployment, poverty, inadequate education and other socioeconomic disadvantages.

References

1. White, Evelyn C., ed. *The Black Women's Health Book: Speaking for Ourselves.* Seattle, Washington: The Seal Press, 1990, pages 4–10, 38–43, 151–155.

2. National Center for Health Statistics. *Vital Statistics of the U.S.* 1988.

3. Edwards, K.A., Dr.P.H., *et al.* "Cardiovascular Risks: Among Black and White Rural-Urban Low Income Women." In *The ABNF Journal,* Fall 1991, pages 72–75.

4. *Healthy People 2000: National Health Promotion and Disease Prevention Objectives.* United States Department of Health and Human Services, Public Health Service, September 1990, pages 137–138, 391–478, 416–440, 442–478.

5. *Women's Health: Report of the Public Health Service Task Force on Women's Health Issues, Volume II.* U.S. Department of Health and Human Services, Public Health Service, October 1987, pages II.31–33, II.37–47, II.58–61.

6. *NHANES, 1976-1980.* National Center for Health Statistics (extrapolated to 1989 population).

7. The AARP Minority Affairs Initiative. *A Portrait of Older Minorities.* Washington D.C.: American Association of Retired Persons.

8. *Health Risks and Preventive Care Among Older Pacific/Asian Americans.* Washington, D.C.: American Association of Retired Persons.

9. *Regional Differences in Indian Health.* U.S. Department of Health and Human Services, Public Health Service, Indian Health Service, 1991, pages 36–37.

10. *1990 Vital Statistics Report: North Dakota.* Bismarck, North Dakota.: North Dakota State Department of Health and Consolidated Laboratories.

11. *South Dakota Vital Statistics and Health Status: 1990.* Pierre, South Dakota: South Dakota Department of Health, October 1991.

12. *Colorado Vital Statistics, 1989.* Denver, Colorado: Colorado Department of Health, July 1991.

13. *Montana Vital Statistics, 1988-1989.* Helena, Montana: Montana Department of Health and Environmental Sciences, May 1991.

14. *Utah's Vital Statistics Annual Report: 1988.* Salt Lake City, Utah: State of Utah Department of Health, May 1990.

15. "Facts About Breast Cancer, Mammography and Black American Women." Press Release. National Cancer Institute, November, 1991.

16. *Cancer Statistics Review, 1978-1988.* National Cancer Institute, U.S. Department of Health and Human Services, Public Health Service, National Institutes of Health, 1991, pages II.4–7, III.5–7, IV.12–15.

17. *Preventable Cancer Mortality in American Indian and Alaskan Native Women.* U.S. Department of Health and Human Services, Public Health Service, Indian Health Service, May 1990, pages 12–23, 32–39.

18. Segal, Marian. "Breast Cancer: Complacency the Enemy of Cure." In *FDA Consumer.* U.S. Department of Health and Human Services, Public Health Service, Food and Drug Administration, July-August 1991, pages 7–13.

19. "Investing in Older Women's Health, Issue Brief." Washington, D.C.: Alliance for Aging Research.

20. Brown, Helene, *et al.* "Cancer and Women." In *Women's Health Issues, Region X: Proceedings of 1990 Women's Health Issues Conference.* Public Health Service, 1992, pages 127–136.

21. Bass, L.B.P., and F.H. Guckes. "Medicaid Coverage of Screening Tests for Breast and Cervical Cancer." In *American Journal of Public Health,* February 1992, Volume 82, Number 2, pages 252–253.

22. Morris, Donna LeBlanc, *et al.* "Cervical Cancer, A Major Killer of Hispanic Women: Implications for Health Education." In *Health Education.* Association for the Advancement of Health Education, December 1989, pages 23–28.

23. *Cancer Facts and Figures for Minority Americans.* Atlanta, Georgia: American Cancer Society, 1991, pages 17–20.

24. *Highlights: A Study of Black Americans' Attitudes Toward Cancer and Cancer Tests.* Atlanta, Georgia: American Cancer Society, January 1981.

25. *A Study of Hispanics' Attitudes Concerning Cancer and Cancer Prevention.* Atlanta, Georgia: American Cancer Society, May 1985.

26. *Health Risks and Preventive Care Among Older Asian/Pacific Americans.* Washington, D.C.: American Association of Retired Persons.

27. *Minority Aging: Essential Curricula Content for Selected Health and Allied Health Professions.* U.S. Department of Health and Human Services, Public Health Service, Health Resources and Services Administration, 1990, pages 231–232.

28. *Health Risks and Preventive Care Among Older Blacks.* Washington, D.C.: American Association of Retired Persons.

29. "Indian Women's Health Care Consensus Statement." U.S. Department of Health and Human Services, Public Health Service, Indian Health Service, 1991, pages 7–10.

30. Dever, G.E. Alan, Ph.D. *Migrant Health Status: Profile of a Population with Complex Health Problems.* MCN Monogragh Series, Migrant Clinicians' Network. Austin, Texas: National Migrant Resource Program, Inc., 1991, page 8.

31. *Health United States, 1990.* Hyattsville, Maryland: U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control, National Center for Health Statistics, 1991, page 27.

32. "Arthritis Discriminates Against Women." News Release. Denver, Colorado: Arthritis Foundation, Rocky Mountain Chapter, May 1991.

33. *Facts About Arthritis.* Atlanta, Georgia: Arthritis Foundation, 1991.

34. Reisine, Susan T., *et al.* "Work Disability Among Women with Rheumatoid Arthritis: The Relative Importance of Disease, Social Work and Family Factors." In *Arthritis and Rheumatism*, Volume 32, Number 5, May 1989, pages 538–543.

35. *Systemic Lupus Erythematosus.* Atlanta, Georgia: Arthritis Foundation, 1990.

36. *What Black Women Should Know About Lupus.* U.S. Department of Health and Human Services, Public Health Service, National Institutes of Health, National Institute of Arthritis and Musculoskeletal and Skin Diseases, July, 1991.

37. "Glaucoma." In *The Bridge*, Missouri Office of Minority Health, Volume 3, Number 1, Winter 1992.

Panel Presentation

Silvia G. Corral, M.D., M.P.H.

This is my first opportunity to address a group of women on the issues of health. What a great feeling! More thrilling is to see the individuals from different areas of expertise (community organizing to health care delivery) in the same room discussing minority women's health care. As a family physician who has been working with underserved populations, and as a minority woman with mother, sisters and nieces, I have been concerned at the lack of interest in addressing women's health, and minority women's health even less so. This lack of interest is manifested by insufficient data and resources.

I'd like to add to what has not been said: we are facing a demographics change in the Hispanic population which is expected to increase by 9–10 percent. Illiteracy is at greater than 12 percent of the population and we do not know its impact on health. We have differences in culture, language, fertility, and the four or five possible effects of acculturation which also impact this population.

I hope this presentation is as visually pleasing to you as it is informative.

Chronic disease is a term used for a variety of illnesses from heart disease to arthritis. It includes diseases we believe can be prevented as well as those that are genetic, such as sickle cell disease. Chronic diseases often have no initial disabling symptoms which initiate a doctor's visit. They continue over time—silent, with exacerbations, complications, the development of disabilities—and they most often lead to death. They consume health care resources and affect the quality of life.

This picture tells the story today of the mortality from chronic disease. Heart disease, stroke and cancer are the leading causes of death among minorities. These are also the leading causes of death in non-minority populations, but the rates are considerably different—from one-third to two times greater. The data is incomplete because it does not tell you the age of onset, age of death, or associated morbidity (pain and disability). National women's data is best collected for Black women, then Native American women, and now recently Hispanic women. Local and regional data that are included in your background paper are difficult to interpret. Isolated studies of minority women in different settings are the best data we have to date.

In talking about chronic disease, I am going to focus on the known strategies for risk reduction, early detection and treatment. It will be our challenge in this conference to prioritize, to operationalize, or to propose new strategies to reduce the effect of chronic disease among our population of minority women.

Evaluate these recommendations through the eyes of a woman of color who is balancing cultural values, family responsibilities and daily tasks, and the use of limited resources, whether it be money, language abilities, time or transportation. Ask yourself, Are these services available? Who provides them and are they acceptable and accessible? Are they being used by minority women? How can we reduce deaths from heart disease and stroke?

We can detect and treat high blood pressure. Black women have a four times greater prevalence of high blood pressure. Hispanic women over 60 surpass Black men in high blood pressure rates. Elderly Asian/

Pacific Islanders may have the most uncontrolled high blood pressure. The 1970's had many high blood pressure demonstration projects aimed at minority people. They are successful in improving control. Yet detection is only as effective as access to regular ongoing care and medication. Medication which has become more expensive with our new medical approach to high blood pressure is less accessible.

If we become smoke free, that will have the greatest impact on cardiovascular disease and also lung cancer. Actual smoking rates for women and Black women had been decreasing. Dangerously, we are seeing a rise in teenage smoking among Hispanic and Asian/Pacific Islander groups. Media promotion and peer pressure to smoke have been shown to be the most significant factors in smoking behavior. Smoking cessation programs are at best 30 percent effective. The new nicotine patches promise better efficacy, but they are expensive and not reimbursed by third-party insurance.

We can lower cholesterol and promote a diet with less than 30 percent of its calories from fat. High cholesterol levels are a risk factor for cardiovascular disease. How do we change dietary habits of families and culture? What are effective educational strategies? Are cholesterol-lowering medications effective in minority women? Can we afford to treat high cholesterol with medications?

We can encourage exercise and maintenance of a lean body weight. Forty-four percent of Black women over 20 are overweight, 40 percent of Hispanic women are overweight, and 30–75 percent of Native American women are overweight. I'm overweight! Obesity is a complex risk factor. We are not quite sure how it increases your risk for heart disease, stroke or diabetes, but it definitely limits a woman's ability to remain healthy. Obese women have more diseases. Obese people are discriminated against by the medical care system. Regular exercise can reduce cardiovascular disease by promoting a protective factor—HDL—and achieving weight reduction. Strategies for minority women to engage in regular exercise are missing. Culturally sensitive models are few. Understanding of the factors of obesity in our population is deficient.

This picture shows graphically the correlation between obesity and diabetes. Most women with Type II non-insulin dependent diabetes are obese (up to 99 percent) before they get the disease.

We can treat diabetes easily and aggressively. It is the silent killer affecting the small blood vessel circulation of all major organs. Diabetes is a major illness for all minority women. Black women have a 33 percent higher prevalence than White women. Hispanic women are at 300 percent greater risk of getting diabetes. Native American women can have from 20 to 50 percent of all their tribal members with this disease. American-born Asian/Pacific Islanders have twice the rate and mortality from diabetes than their foreign-born counterparts.

Diabetes is one of the most disabling diseases. Without diet control, weight control and medical control, people with diabetes have 30 percent more heart disease, develop hypertension, have 50 percent more strokes, become visually impaired, suffer recurrent infections, have amputations of extremities and develop kidney failure requiring dialysis. Access to culturally and linguistically appropriate education, to ongoing medical care and medication, and to nutritional support are essential.

The three leading cancers in women are breast, cervical and lung. We know that cancer may be preventable with changes in diet and behaviors, and we are certain that early detection and treatment can cure from 60 to 95 percent of these cancers. Minority

women die at higher rates from cancer than White women.

Breast cancer is less prevalent in Black and Native American women, yet the mortality from this disease is greater by 30 percent. Breast self-exams can be as sensitive as 90 percent in finding breast cancer, yet Black and Hispanic women are less likely to know about BSE. Mammogram screening in post-menopausal women can detect early cancer, yet minority women are only accessing mammograms at 30 percent, even when cost is not a barrier.

Cervical cancer is the third most common cancer for Hispanic women. We can detect it early with a Pap exam. What we know about minority women's behavior in accessing Pap exams is not very encouraging. Increasing access does not translate into minority women having more Pap exams. In a recent study, 20 percent of Hispanic women had never had a Pap exam, 60 percent had at least one in their lifetime, and less than 20 percent had yearly or every-three-year Pap exams. We have an educational gap. Even if we are able to obtain Pap exams, there are system barriers to evaluation and treatment. Not all minority women qualify for Medicaid or are insured through their work. This is a disease of young working women, a tragedy when detection or cure is not offered.

Very unique cancers are stomach and esophageal. New Mexican Hispanics, Chinese and Japanese women in the U.S. have higher rates. We hypothesize that these cancers are associated with diet.

Lastly, I must mention arthritis and collagen vascular disease such as rheumatoid arthritis and systemic lupus. These diseases affect all women, two-thirds of all affected are women. These diseases are disabling and impact on the economic productivity of women. The effort to prevent osteoporosis in minority women is not visible. The research on arthritis and collagen vascular disease must include minority women.

Thank you for listening—we are here to learn from each other; to be like a mother and nurture; to be like a daughter and make new visions.

Focus Group Reports

Background

Fifteen focus groups met during the Forum to discuss each major track topic from the perspectives of (1) ethnic or racial influence; (2) the life cycle of the woman from menarche (onset of menstruation) through young adulthood, midlife, maturity and the elderly years; and (3) interagency linkages or systems challenges. Three focus groups addressed each one of the five track topics from the standpoint of one of these perspectives. The focus group reports follow.

FOCUS GROUP I—RACIAL OR ETHNIC INFLUENCES

Problem

Barriers and lack of access for women of color to primary care and various related factors

1. Absence of one-stop shopping facilities
2. Lack of culturally sensitive providers
3. An acute-care, high-tech focus versus a preventive and continuous approach to care
4. Negative image of putting self ahead of spouse and children, a sense of guilt for taking care of one's own health, self-worth
5. Lack of resources (dollars) to pay for mental health, alcohol or drug treatment services
6. Psychosocial risk factors of total health and a need for providers to pay attention to the total presenting conditions and not just those which are physical
7. Changes in women will trigger changes in other family members.
8. Lack of good research on why women of color are not accessing care, not enough research within the various ethnic groups
9. Language barriers, literacy levels
10. Transportation and day care to get to needed services
11. Program eligibility insults which demean and destroy pride in those needing publicly funded care
12. A lack of trust for established programs and staff

13. Inappropriate standards by public health agencies for measuring program effectiveness; a need for flexible standards that allow shifting of resources to address other aspects of total care

Interventions

1. Use more community focus groups to identify what will make a difference.
2. Train providers in cultural sensitivity.
3. Use community people to train the community members—empower the community.
4. Change the focus of programs and services to do more outreach.
5. Let the community identify needs and concerns.
6. Take services to the people, rather than expecting the people to come to the service if this is what the people want and accept.
7. Identify and work with community leaders.
8. Recognize and accept clients' spiritual beliefs.
9. Change standards (Bureau of Primary Health Care) as to how effectiveness is measured and include psychosocial measures.
10. Assure that psychosocial issues are part of the care intervention.
11. Refund costs for on-the-job training in order to train community health resource people.
12. Link efforts to improve literacy to goals for health improvement.
13. Develop and test culturally sensitive materials.
14. Funding agencies should recognize that being a woman amplifies any of the other underserved populations.

Barriers

1. Inflexible policies and institutions
2. Resistance of the care providers
3. Productivity measures too strongly focused on encounters; these changes are labor intensive

4. Lack of commitment to embrace cultural diversity
5. Conflict between community values and interests
6. Lack of knowledge about successes in overcoming access issues
7. Ineffective use of existing resources and a lack of dollars
8. A lack of grassroots (on-site) decision making

FOCUS GROUP II—WOMEN'S LIFECYCLE

Diabetes—a serious, incurable disease for women of color which has a low profile and which is underfunded

Problem

1. Lack of information
2. Lack of knowledge or misinformation
3. Association with other diseases
4. Genetic predisposition for Hispanics and Blacks
5. Cultural barriers—diet (ethnic influence)
6. Detection (can't detect until present)
7. "Here and now" syndrome and cultural influence
8. Resources
9. Research for Type II is not prevalent.
10. Debilitating conditions: eyesight, kidney, circulation, short-term memory loss, etc.
11. Shorter life expectancy
12. Longer period of disability
13. Environmental hazards for migrants and the high costs of obtaining the "right" foods

Interventions

1. Diet—children and family
2. Weight control

3. Proper prenatal care for pregnant women
4. Targeted groups—high profile
5. Lifestyle issues
6. A return to ethnic roots for people of color—i.e., African-American, Mexican, Oriental

Barriers

1. Against state law in Montana to have lay health aides dispense health education—don't stay in area long enough to train
2. Funding—lack of resources, both financial and personal
3. Cost of and access to food

Diabetes is a chronic and serious disease that disproportionally affects women of color throughout the lifecycle. It deserves more attention and resources through culturally appropriate education, treatment and research.

FOCUS GROUP III—INTERAGENCY LINKAGES OR SYSTEMS CHALLENGES

Brainstorming

1. Racial/ethnic influences—psychosocial
2. Stresses and mental health issues affecting women of color
3. Broad scope
4. Chronic disease linkages to other tracks—mental health, substance abuse, violence, reproductive health
5. Issue focus versus disease focus
6. We are talking about lifestyles versus just disease
7. Minority issues: access to services, outreach to services, early intervention plans, funding impact (e.g., of migrant women, community health RN's)
8. Issues affecting migrant women: pesticides, children in the fields, community health issues, what can be done

9. Instead of focusing on one disease, consider issues that affect across the spectrum such as psychosocial issues, access issues, early educational concerns, poverty-related issues
10. Rather than having a specific focus or special topic, the focus will be on chronic disease as a general problem and prevention

Problems

1. Problem may exist for which research (better and clearer data) is missing for specific minority populations
2. Who produces the data? How is the data managed? Is the data presented in a culturally sensitive and scientifically correct way? Is data showing ethnic and racial differences really just measuring economic status?
3. Data collection, reporting and usage has to be ethnically "competent," or perhaps ethical?
4. Ethnic "competency" and empowerment are important concepts in medical research.
5. Further development on the importance of sensitivity issues is needed; how does sensitivity assure implementation, competence and the provision of services?

Good intentions do not result in competent behavior or successful outcomes.

Barriers

1. Misleading data
2. False hopes, e.g., a woman comes in once a year for Pap smear, has access to Medicaid but can't get services due to lack of transportation, child care
3. Lack of awareness of educational methodologies which work and are easily understood by women of color. Need for culturally aware, community-conscious people who are truly knowledgeable about cultural tendencies within certain programs (e.g., Native American women who are agreeable and nodding but do not understand technical aspects of what they have been told).
4. Financial problems and the cost of services
5. "Machismo" issues

6. Issues of immigration status such as language and other cultural barriers
7. "If it ain't broke, don't fix it" attitudes
8. Importance of making the family see that it is the most important entity
9. Concern as to whether acculturation impedes health status of Hispanics, Asians and Native Americans. The impact of environmental problems—stress, pollution, diseases of urban life
10. Cultural issues and barriers, such as "machismo"
11. Need to evaluate programs on "good outcomes" rather than "good intentions"
    a. Many systems report accomplishments and yet women of color continue to die.
    b. Racism, sexism, stereotyping
    c. Decay of social net has fallen on the backs of women; although intentions are good, there is a backdrop of "bad intentions," such as cuts in family planning, in programs for single parents, educational services, in services for children, etc.
    d. The issues which affect the general population may or may not affect people of color the same way.
    e. Demonstration grants which are not meant to address or "demonstrate" positive outcomes and which do not require integration with existing institutions
    f. Programs which purport to address a chronic disease, but which do not provide resources for poor people to access these programs
    g. The health "system" is not fully developed and lacks adequate resources for prevention which meet the needs of physicians, health educators, community outreach workers, school health services, etc.
    h. Migrants, homeless, and Native American peoples all encounter "systemic" structural problems and issues which need to be bridged. These systems include private physicians, community health clinics, Indian Health Service, voluntary agencies, private non-profits, community outreach services, etc.
    j. Lack of cooperation and integration of programs resulting in major chronic disease programs not being aware of the issues of women of color

k. Providing care for populations of high need given the current climate of limited dollars and other resources

l. The need for an alternative to the medical model which includes social work and health communications and which considers the family context, lifespan issues, income and transportation issues, and empowerment of the individual and the community

m. The need for "centers of prevention" which integrate the work of private efforts (e.g., Robert Wood Johnson, the Pew Trust, etc.) with national health efforts—prevention must be institutionalized in the U.S.

Problem Statements

1. Narrow and inflexible structures for funding the provision of care and services for communities of color, leading to unsuccessful health outcomes

2. Institutionalization of disease focus causing fragmented funding and service delivery

3. There are special interests in place that perpetuate the disease-oriented system.

4. Prevention has not been institutionalized in the United States.

5. Need for prevention, social, holistic models which incorporate the concepts of community empowerment, lessons from social marketing and health communications that see the individual within the context of family, ethnic, cultural and regional particulars

   A "coalition" structure is needed for minority women in chronic disease areas which brings together at the local level private physicians, community organizers, private industry, public health, community health centers and federal resources.

6. Health care continues to have a disease orientation and fails to consider cultural relevance, behavioral factors, family context, and social requirements (e.g., job requirements, transportation, child care, etc.) and does not foster prevention. This results in health and health-related social programs that are too narrow, inflexible and lack the needed linkages to achieve their goals.

7. The "real" health needs of the minority woman are compromised based on cultural assumptions, traditions, good deeds and good intentions.
8. A problem is identified, and policies are made looking at the big picture but without looking at all the realities that will impact the effectiveness of the policies.
9. The institutionalized "issues"—specifically in this context racism and sexism—are designed and implemented to destroy the family of color in order to continue the current political and fiscal well-being of the United States.

Group Product

Institutionalized health care system continues to have a disease orientation and fails to consider cultural relevance, behavioral factors, family context, social requirements, or regional differences. It does not foster health promotion or community empowerment. This results in health and health-related social programs that are too narrow, inflexible and lack needed linkages to meet the goal of the program. This system is institutionalized to include racism and sexism, which maintains the status quo and benefits the current generic power structure.

Recommendations

1. Develop a vehicle or voice for women of color to come together from private industry, public health, federal agencies, community, and other health-related organizations to address the above issues.
2. Develop a coalition structure for minority women in chronic disease areas that will force a change from the institutionalized disease-focused approach to health care to a health promotion approach that emphasizes community empowerment, cultural relevance, behavioral factors, family context, social requirements and regional particulars.

Chronic Disease Track Report

The track group agreed that "chronic disease" has a negative implication, and suggested the term "holistic health care" instead. The participants agreed that the institutionalized health care system that currently exists continues to have a disease orientation and fails to consider the cultural, spiritual and behavioral backgrounds of women of color. The system also fails to consider family context, social requirements and the diversities of the regions of the country. Additionally, it fails to foster health promotion and the training of culturally sensitive providers. It does not empower communities nor does it promote grassroots decision-making.

This results in health and social programs that are too narrow, inflexible and rigid to meet the needs of women of color. The programs and delivery systems are institutionalized, include racism and sexism, and are designed to benefit the current generic power structure. The impact of these systems is that people do not have access to care, the system imposes programs that are not always the priorities of the people, and services are provided which are insensitive to local needs, thus creating barriers to obtaining care.

The chronic disease track group presented the following recommendations:

1. The development of a vehicle or voice for women of color in order that they might come together with representatives of private industry, public health, governmental agencies, community organizations and other health and human service organizations to address the holistic approach to health care. The groups should also include representatives of transportation, marketing, etc.

2. The establishment of community coalitions of women of color, including grassroots participants, in order to force change from the institutionalized disease-oriented approach to health care towards a health promotion model that emphasizes community empowerment and cultural relevance, and addresses psycho-social concerns

3. The expansion of cultural sensitivity training for all health and other human service providers

4. Encouragement of providers to recognize, understand and appreciate the spiritual beliefs and values of women of color and their families

5. Placement of increased emphasis on the availability of primary and preventive health care services for all population groups, including rural, frontier, etc.

Opening Ceremonies

Mental Health & Minority Women

Substance Abuse & Minority Women

Violence & Minority Women

Reproductive Health & Minority Women

Chronic Disease & Minority Women

The Policy Process 7

State Recommendations

Appendix

The Policy Process

The Policy Process and Its Relevance to the Health Status of Women of Color

Catherine M. Crawford, Ph.D

Perhaps you think that public policy is boring. Well, whenever people speak to me about policy, what it is, and how to change it, you've got my attention, my interest, you've touched a chord.

In fact, when I think of public policy, I think of champions. As children, we tend to cherish certain people, those men and women whom we hold up as special, perhaps perfect, certainly people whom we hold in high esteem, and we wish that someday, we can be like those champions. As a child, I had two such champions or heroes. Well, actually I had three. One was Mickey Mantle, a player on the New York Yankees, but he really doesn't fit into what I want to say today. However, the other two were John F. Kennedy and Elizabeth Blackwell. John Kennedy, was, of course, a former U.S. President who instilled a desire to enter the public service and make a difference. Elizabeth Blackwell was the first female physician in this country. Both had a tremendous impact on public policy and the lives of individuals.

Just as all of public policy impacts on the lives of individuals, health policy impacts on the health status of individuals. However, health policy is not completely separate from other actions of the public and private sectors. Health policy is linked with other policies that attempt to address societal problems and needs, such as poverty and homelessness. For example, those who cannot work and receive some sort of public assistance may also be eligible for public health insurance under the Medicaid program. Also, homelessness is not merely a "housing problem." It is connected to other ills in our society, such as drug use and mental illness. Thus, the health issues of our nation are intricately woven throughout the fabric of our society.

And because of that, many government policies that address one problem may not produce the intended effect and may even produce unintended consequences (Crawford, 1991). Indeed, it has been stated that "over the last three decades many years and multiple megadollars of policy research have not improved American social welfare policies . . ." (deLeon, 1992:125).

So what can you do? How can you have an impact? In light of these failures, it has been suggested that we must look to who is included in the policy process in order to

make policy that is effective. We must begin at the beginning. Who defines the problem? Who begins the process? Who is included in the making of policy?

Without the incorporation of those persons most immediately affected by policies under consideration, it should come as no surprise that we have failed in some measure. The issues have not been viewed as they are experienced by the intended recipient and the end result has been program failure (deLeon, 1992:125). In his article titled "AIDS in Blackface," Dalton poignantly illustrates the problem (Dalton, 1990: 250-251):

> When we want help, white America is nowhere to be found. When, however, you decide that we need help, you are there in a flash, solution in hand. You then seek to impose that solution on us, without seeking our views, hearing our experiences, or taking account of our needs and desires. . . . Why can't we choose which of the many problems facing us to tackle first?

And that is what you are doing at this conference. Choose the problems that you want to tackle first. Policies and programs that just haven't done the job are currently producing two basic questions asked among researchers and practitioners. And in fact, Dr. Margueritte White posed these questions to us yesterday. The first question is: How do we make policies that actually affect in a positive manner those problems that we identify? The second question is: How do we make policies that are responsive to popular control (Lindblom, 1980)?

Both of those questions are related and are at the heart of this conference. We cannot achieve effective policies without incorporating the experiences and desires of the people targeted. Therefore, I would like to place those questions in this form: How can women of color impact the policy process to achieve desired policy and program outcomes?

Women of Color—Do they really need special attention?

Health is a basic privilege of life. While as individuals we can make choices that can enhance our health, health is also influenced by sociological factors, including gender and race (Anderson, 1988). The influence of gender and race on health status has been recognized by the U.S. Public Health Service in its reaffirmation of "women's health as a national public health priority" (U.S. Department of Health and Human Services, 1991:1) and in its support of this conference. However, why is it that women of color are being designated as requiring special attention in the development of public health policy now? Perhaps because, simply put, it's about time.

Women of Color's Health Status. Some of the health problems encountered by women of color and White women are the result of women's physiology and the experience of being women in our society. And we heard yesterday many examples of the differences in the experience of health status between men and women. That the health experience and status of women is different from men is known (Almquist, 1989). But we have not examined the extent of those differences, the causes of those differences, and possible solutions to the problems. Yesterday, Dr. Mason pointed out that the National Institutes of Health and other agencies have recently begun to encourage such studies. However, the past is replete with examples in which women's health status was not a concern.

For example, in one study of the relationship between dieting and exercise, 42 overweight men were studied. No women were included. Apparently, despite Dr. Silvia Corral's convincing admonition that "We're

fat!" there were no overweight women to be found. Another study included 22,071 subjects who were male physicians. The purpose of the study was to determine whether a low dosage of aspirin helps prevent cardiovascular deaths. Again, there must have been no female physicians to be found. Someone must have asked, "Is there a female doctor in the house?" I can only guess that the house must have been a college fraternity. A total of 3,154 subjects were studied to ascertain the association between Type A behavior and increased heart disease. The subjects were all men—California businessmen. It must be that no California businesswomen were included because the funding agencies still wished that they all could be California girls. Another study of 7,735 men aged 40–59 analyzed the links between everyday activities, breathlessness, and cardiac disease. Again, there were no women included in the study. It is one thing to include women in a study and then not search for gender or racial differences. It is quite another to leave them out of the study completely—as if we didn't exist.

Other health problems among women of color are the result of possessing minority status in this country and the impact that status has on the health of women. Women of color face all of the problems faced by White women. They bear children, go through menopause, work, have relationships with men and other women. They also experience rape, discrimination, harassment, and other mistreatment that occur because of their sex. While women of color share all of these experiences with White women, they live within a framework that is different. They experience the world in a manner that is not the same as that experienced by White women (Freeman, 1989). As minorities and as women, they have suffered all the burdens of prejudices that are part of both territories (Chafe, 1979). Therefore, minority status adds confounding aspects to the health status of these women, and we have been provided many examples of this. And yet, Dr. Marilyn Gaston showed in her series of slides that we don't have sufficient information to understand these differences. However, the data we do have indicate that the health status among different minority groups is different and is significantly influenced by societal and cultural factors. Therefore, there is a clear and present purpose for the discussions in which you are engaged today. First, the health status of women is different from the health status of men. Second, the health status of women of color is different from the health status of White women. Third, health status among women of color varies significantly, depending upon race and ethnicity. Fourth, many health issues overlap and are the result of being both female and minority. Fifth, the health status of women of color has not received the attention, money, and research emphasis necessary to discover the specific causes of and solutions to those problems.

In order to effectively address the health problems experienced by women of color, it is important to place the context for change within a plan that (1) understands the policy process in what I'll call its institutionalized form, then (2) determines how you can positively impact upon that process.

A Traditional Perspective on the Policy Process

The policy process is quite complex, but it can be presented as a series of six phases (Brewer, 1974; Brewer and deLeon, 1983). Those phases are initiation, estimation, selection, implementation, evaluation, and termination. Initiation begins with the identification of a problem and definition of objectives. During estimation the alternatives are investigated and scientifically examined. In the

selection phase, the identified alternatives are considered and debated. Then, through compromise, bargaining, and the inclusion of rational considerations, a choice among the options is made. During implementation, the decision is translated into operation, and program goals and schedules are set up. At some point after a policy or program has been implemented, an evaluation typically occurs. Finally, a policy or program is expected to be reviewed and reductions or termination are considered in this stage. This idealized version of the policy process is acknowledged to be just that—idealized. The process is typically not sequential and the order in which these phases occur for any given policy usually ends up being rather "messy." For example, many times the problem is not defined (Weiss, 1989). Rather, we define the problem in terms of its symptoms. How many of you have taken aspirin or Tylenol to get rid of a headache? Well, the headache is the symptom. The cause of the headache could be stress, a brain tumor, or perhaps wearing a hat that is too tight. Remove the distress, remove the brain tumor, or take off the hat, and *Voila!*, the pain is gone. But because you did not remove the cause of the pain and treated the symptom, the pain returned as soon as the medication wore off.

While there are many other kinds of pitfalls within this process, I'd like to use this framework to suggest that the attendees at this conference are probably in the first and second phases of the process. You have identified the problem, objectives are being more clearly defined, and alternatives are being considered. But although you may be in unanimous support of these objectives, is unanimous support among 200 or so people enough to achieve those objectives within your region, your state, or your local community? Probably not. More to the point, how does this body influence public policy in the area of women of color's health status? This framework does not show us how to make your goals and objectives the goals and objectives of those who are in power. In order to influence public policy, you need to make sure that those in power, whether at the local, state, or national level, also understand the problems and share in the desire to achieve similar objectives (Dye, 1987; Key, 1967). And that may not be so easy. While government is in the business of making decisions regarding the distribution of resources, changing public policy is the business of redistributing those resources (Lowi, 1966). Most people understand that we are no longer a nation with unlimited wealth. There are just not enough resources to provide for all of the health care deemed necessary and adequate to all of the people in this country. Therefore, if you are asking for a bigger piece of the pie, understand that since the pie can get no larger, a larger piece for you means a smaller piece for others.

How, then, do you convince those who have the power to significantly influence the success of your agenda that such a redistribution should occur? And how do you do so when those in power may not be women and minorities? While we have Jane Artist, Dr. Audrey Nora, Dr. Marilyn Gaston, Dr. Agnes Donahue, and others in positions of power, there should be a strategy that brings more women and minorities into positions of power. However, your agenda today must be met before we can do so, so let us take some lessons learned from the Women's Movement and apply them to the strategies you are developing.

How to Win Power and Influence Policy

Your purpose is to affect public policy, to make social change. And make no mistake, social change is the goal, and only through a

social movement can that change be made. Traditionally, social movements have been viewed as a one-way relationship in which social movements affect public opinion, which then affects public policy (Barber, 1984).

The process, however, is more dynamic. A social movement is typically effected by people who have organized as a result of being strongly affected by certain social conditions. Therefore, it is the way in which we live that effects change—it is on an individual and community level, not a national level. Furthermore, the path to changing policy is more complicated than the traditional perspective. A mutual relationship between social movements and policies is created by which resources are produced by the movement for those within government to use in pursuit of common goals. Those resources are not just affecting public opinion. They include providing information, ideas, skilled help, publicity and lots of warm bodies (Freeman, 1975). There are strategies that can be used to advance your cause by generating these resources.

First, generate publicity—a lot of publicity—on the health status of women of color. It will inform and it will legitimize your objectives. Get the information into newsletters and local papers. Speak on your local radio station; get on your local TV talk show. Get to know your local press. Take your favorite reporter to lunch. Do what the American College of Nurse Midwives does. After each conference, they return to their communities and call up the women's section in their local paper to report about the wonderful conference. Why don't each of you call up the women's section, or the minority or health section of your local paper when you return home?

Second, create a climate of expectation that something can actually be done. This means that you must choose your objectives carefully. Short of a miracle, eliminating domestic violence by the year 2000 throughout the United States is just not doable. But many other things are. Dr. Martha Wunsch told us of the 16-year-old alcoholic mother whom her clinic is successfully treating. This is a success! Find out why and repeat it. If you repeat it just once, for a single woman in every clinic in this region, then won't we be better off than we are today?

Third, enable your supporters in government: create a constituency that those in government can use to help you. For example, the Public Health Service has already helped. They need to be able to point to a public, politically active movement that requires solutions to be found for problems. Be that group—for the Public Health Service, for the National Institutes of Health, for any other government agency at the local, state, or national level that can help you. Form good relationships with those in the public sector who are already on your side and share information with one another. Fourth, provide information to those in government and the Congress. Make sure that the health care providers, those "in the trenches," get to testify before government committees, civic groups, and local school boards.

Fifth, supply grass-roots support. Have your constituencies write letters to your state and national legislators. Write to governors, to mayors. Attend meetings. Plan conferences such as these in your communities. Participate in demonstrations.

Sixth, expand and diversify by reaching out to other groups. Co-opt interest groups that are already established and known to be responsible organizations. For example, consider interest groups related to women, minorities, senior citizens, and the health care field. Look at the list of 25 contributors to this conference that is in your book. Make a note of them.

In addition, incorporate groups that might be labeled "radical" or "nonconformist." These groups can make your movement appear relatively conservative and legitimate.

Finally, remember to support and place pressure on public agencies. You are the client and you are significantly affected by the polices and programs they develop. Help them understand the problems and pressure them to alleviate those problems (Freeman, 1975).

Conclusions

The people in this room today share a common bond. There is a desire and recognized need to improve the health status of women of color. And there is understanding that, as women and as minorities, health status is not so much a measure of how often you get a cold, but a measure of your place in society. Therefore, it will take more than a common bond to get the job done. First, you must get the attention and the cooperation of those in power, and not only at the national and state level; you will probably be more effective at first at the local level. Remember, policy does not have to start at the top. And good policy most often "bubbles up" from the bottom. Second, you must help to develop policies and programs that are really going to make a difference, at any level.

I began today with a list of my childhood champions. As I grew older, I accumulated more heroes and heroines and dropped a few along the path to adulthood. And a funny thing happened along the way. My champions have changed quite a bit. Most are not household names, have not been in the public eye, have not been world-class leaders in government or science. You would not recognize the names of most of my champions. But you would recognize the qualities they share: they have fought to change a piece of their lives and the lives of others, with their dignity and integrity intact. They fought to change the rules, the policies, that significantly and intimately affect our daily lives.

Public policy is more than declaring war on another nation, more than declaring a War on Poverty. It's deciding which children will get inoculated, and where the local medical clinic will be placed in a town. It's a group of women marching to take back the night. It's a group of parents fighting to take back their neighborhood from drugs and violence.

I've heard that it's hard for our children today to find champions. There are no real heroes and heroines anymore. Look to yourselves to become the leaders who make change. And then, perhaps, you can become the champions upon whom the next generation looks and says, "Hey, they made a difference!" Because you not only affected policy, you improved the lives of the individuals and families in our communities.

References

Almquist, Elizabeth M. "The Experiences of Minority Women in the United States: Intersections of Race, Gender, and Class." In Jo Freeman (Ed.), *Women*, 4th Edition. Mountain View, CA: Mayfield Publishing Company, 1989, pages 414–445.

Anderson, Margaret L. *Thinking About Women*, 2nd Edition. New York: Macmillan Publishing Company, 1988.

Barber, Benjamin R. *Strong Democracy: Participatory Politics for a New Age.* Berkeley: University of California Press, 1984.

Brewer, Garry D. "The Policy Sciences Emerge: To Nurture and Structure a Discipline." *Policy Sciences*, September 1974, pages 239–244.

Brewer, Garry D., and Peter deLeon. *The Foundations of Policy Analysis.* Pacific Grove, CA: Brooks/Cole Publishing Company, 1983.

Caper, Philip. "The Physician's Role." In Frank B. McArdle (Ed.), *The Changing Health Care Market.* Washington, DC: Employee Benefit Research Institute, 1987.

Chafe, William H. *Women and Equality.* New York: Oxford University Press, 1977.

Crawford, Catherine M. "Endogenous Safety Processes: A Model of Regulation and Safety within Industrial Firms." *System Dynamics Review*, Vol. 7, No. 1, Winter 1991, pages 20–40.

Committee for the Study of the Future of Public Health. *The Future of Public Health.* Washington, DC: National Academy Press, 1988.

Dalton, Harlon L. "AIDS in Blackface." S.R. Graubard (ed.), *Living with AIDS.* Cambridge, MA, The MIT Press, 1990, pages 237–260.

deLeon, Peter. "The Democratization of the Policy Sciences." *Public Administration Review*, 52(2), 1992, pages 125–129.

Dye, Thomas R. *Understanding Public Policy*, Sixth Edition. Englewood Cliffs: Prentice-Hall, Inc., 1987.

Freenlan, Jo. *The Politics of Women's Liberation.* New York: David McKay Company, Inc., 1975.

Key, Jr., V.O. *Public Opinion and American Democracy.* New York: Knopf, 1967.

Lindblom, Charles E. *The Policy-Making Process*, Second Edition. Englewood Cliffs, NJ: Prentice-Hall, Inc., 1980.

Lowi, Theodore J. "Distribution, Regulation, Redistribution: The Functions of Government." In R.B. Ripley (ed.), *Public Policies and Their Politics*. New York: W.W. Norton, 1966.

U.S. Department of Health and Human Services. *PHS Action Plan for Women's Health*. Publication Number (PHS) 91-50214, September, 1991.

Weiss, Janet A. "The Powers of Problem Definition: The Case of Government Paperwork." *Policy Sciences*, 22, 1989, pages 97–121.

Policy Panel Presentations

Grass Roots Policy—Policy With A Vision

Marguerite Salazar, M.A.

What we have heard this morning shows how public policy comes from the top down, typically trying to address a population that is unknown and problems that are not interpreted in the same manner by everyone that policy affects. Public policy by its very nature tends to be both exclusive and restrictive when applied to grass roots populations, with little room for the enforcers of said policy to make adjustments on the spot. When implementing policy that does not quite fit a situation, people in my shoes are often charged with inventing very creative ways to interpret policy in order to insure that the intent of whatever legislation or order the policy is trying to carry out gets pushed forward in the spirit in which it was intended.

That can get very tricky. We then become masters at getting around specific rules that don't fit our populations because we are, in fact, playing a game where the rules must apply but in reality don't apply at all. This is what I see as policy with a purpose as opposed to policy with a vision: a very specific concept that is in fact a shift from traditional interpretation. Existing entitlement programs only entitle people to consume. There is no looking at long-range plans for families or children or women on welfare. "Today you qualify for food stamps. Come back next week and you may qualify for LEAP." Where does this take a single mother of two? Only to next week.

President Kennedy, early in his presidency, made policy with a vision. He said of the space program, "We're going to the moon." And that policy gave scientists the opportunity to get us there in record time. He didn't supply blueprints. He was not prescriptive in his mandates; he gave them a vision to work toward.

In today's real world we try to apply that prescriptive, medical model to all we do. But public policy is not a clinical issue that can be implemented by being prescriptive; it is an issue of leadership and empowerment of the people we want to participate in the process. Public policy as we know it excludes the needs of women and minorities, but the solution to inclusion is not to teach minorities to become just as susceptible to the status quo. Neither do we want separate policy. We want the same things that everyone else wants. We believe in family preservation. Don't tell me my whole family can't come to the hospital with me. We believe in education. Don't tell me Hispanics don't value education and create policy that leads my children into vocational programs. And when we know in our hearts that what holds our culture together is our language, don't tell me that there is an English ONLY policy that says I cannot speak my mother tongue, *porque si se puede!*

We, and I include myself, have a lot to learn when it comes to doing what's right for those we purport to serve. I made a huge mistake about 10 years ago when, after hearing of all the wonderful reasons why women and children should be on WIC as opposed to the USDA commodity program, I began a campaign to get local officials to drop the commodity program and look to instituting WIC. What I did not realize until I finally sat down to talk to the actual recipients of food

commodities was that they preferred commodities because children up to the age of six could participate in the program and WIC cut children out at age five, and many times at age four. They told me that the extra peanut butter they received often made the difference between lunch or no lunch. Despite the fact that I had been told by nurses that they did not know how to use powdered eggs and canned meat, I found that they indeed made wonderful cakes and pancakes with the powdered eggs and dynamite red chile with the canned meat. And when I made my final pleas by reminding them that with WIC you get nutritional counseling, the looks that came my way told me that my values, theories and assumptions for this population really only applied to me. I am a counselor by training. Wasn't it everybody's dream to be counseled in any way, shape or form? That was my dream.

But values, theories and assumptions are very valid issues that we must continue to understand as we implement policy. Public policy with a vision takes all of those things into consideration and lets a family decide what is good for them. We can give people the tools to make those decisions so that policy is not something that is done to them, but something they participate in and work with to meet their needs and the needs of their children. I firmly believe that individuals, parents and families know what they need. We are the ones who make it difficult for them to access services because of our many policies.

We as human service providers must be willing to sacrifice the way we do things to people so that we do not become parasites of the clients and patients we purport to serve. We effect this by first looking at outcomes, and we take a lesson from managed health care or the HMO model that some of you may better recognize, that says, "Here is the outcome we want. You may work toward the outcome in any way you see fit as long as you achieve the desired outcome." This model is working and should be considered for application in public policy.

This type of thought is very empowering to people or communities or organizations. I believe it helps the cream to rise to the top. If I leave you with a few thoughts, let the idea of "Public Policy with a Vision," be one of them. Let's learn to deal with people as people and trust in their capabilities to know what is right for them within that wonderful context called "Public Policy."

Native American Issues

Darlene Johnson, R.N., B.S.N., M.A., C.N.A.

Native Americans have a unique relationship with the federal government. We are sovereign nations. *Sovereign nation* means that the Native Americans have their own governments with their own constitutions and bylaws. Each individual tribe sets its own tribal membership rules. Some tribes in the Oklahoma area set tribal membership on ancestry, while the Sioux Indians in the Dakotas have set tribal membership at one-quarter blood degree. Yet, since 1924, Native Americans have also been citizens of the United States of America. Since many reservations overlap established state lines, the Native American Indians are also citizens of the state in which they reside. This leads to many problems of control and power. Native Americans fall under state, federal and tribal jurisdictions. There is also the problem of urban Indian versus reservation Indian. To receive many benefits given to Native American Indians, such as education, loans, housing and medical care, the individual tribal member must live on the reservation. But to acclimate to the "melting pot," Native American Indians must move to urban settings in order to find employment or some schooling opportunities. Once the individual leaves the reservation, access to these benefits ceases to exist.

The United States of America has made many treaties with the Native American Indians. None of these treaties have been honored by the U.S. government in their entirety. In 1887, the Congress passed a law to stop making treaties with Native American Indians, which had required signatures from three-fourths of the adult males in the tribe. Instead, the Congress chose to deal with Native Americans by passing "Acts" rather than negotiating treaties.

There are just under 500 recognized tribes in the United States, but they have never joined together as a unit to fight the immigration to their land. Each tribal group has its own unique culture, traditions and languages. Even the Sioux of the Dakotas have three different dialects in their language.

I will now respond to the public policy comments made by Dr. Crawford as they relate to Native American Indians in general. Dr. Crawford noted six methods to influence public policy. The first method is the use of publicity to inform people about the realities, conditions and situations affecting the minority group. In Indian country, the publication which we have is the *Lakota Times*, a nationally read newspaper. This news source does not always crosscheck the information it receives. The *Lakota Times* is a very biased newspaper. They need support for their paper and will not publicize news that will disrupt that support. When I was in the role of a Maternal-Child Health consultant for the Aberdeen Area Indian Health Service, I tried to get a weekly health column published in the *Lakota Times*. As a member of the epidemiology team, I had access to professionals in a variety of health prevention areas. But my attempts were to no avail. The *Lakota Times* editor selects the news items, and not all the articles submitted are run.

A second source of publicity is through Indian radio stations. Some tribes have radio stations which carry the National Indian news and some tribes do not have radio stations.

The second method toward changing public policy is to create a climate of expecta-

tion—a belief that something can be done. The federal government has passed a law to support Native American Indian tribes in becoming more independent and in control of the federal programs given to them. One such law is PL 99-638. This law is called the Self-Determination Act. This law requires that the federal government allow Indian tribes to contract for their own programs that are presently provided by the federal government. The federal government is to assist the Indian tribes in becoming self-sufficient. Programs which can be targeted for this 638 law include health care, education, law enforcement, etc. The federal government programs are to give extensive assistance in planning and accomplishing this task. This has been extremely positive within some tribes and not effective in others.

Some of the policies developed by Congress have been on a grand scale. Congress passed a law, the 100 initiatives dealing with Fetal Alcohol Syndrome, or as it is known as an acronym, FAS. The law requires IHS to determine the FAS rates in each area by 1990 and then by 1994 the FAS rates are to be reduced to 1 per 1000 live births. Rates in the Aberdeen area were over 10 per 1000 live births. Obviously, the expectations are too great to even be addressed, let alone rates mandated, by a certain year.

The third method is to enable supporters in government—create a constituency through publicity. The tribal governments go directly to Congress when they want to effect change in policy, funding, etc. The tribes can work through their state congressmen and legislatures to voice their concerns. In the Dakotas, we have one congressman and two legislators. We have a voice in Congress, but not a strong voice.

The fourth method is to provide information to supporters in government: data and testimony. The tribal governments are continuously going to Washington D.C. to give testimony on the plight and condition of the Native American Indian. One issue dealing with data is the census. The census data does not reflect the true populations that the tribes register according to their enrollment numbers. The Rosebud Sioux Indian Tribe has over 18,000 enrolled members, but the census shows us just over 16,000. This is crucial because the funding is based on data such as the census.

Data is constantly fed to the federal government through this process. It is this data upon which policies concerning Native American Indians is decided.

The fifth method is to supply grass-roots support—constituent mail, meetings, conferences and demonstrations. I am very much in favor of grass-roots efforts. The Native American people have to buy into the programs addressing them or the programs will not work. I have often felt that the Indian Health Service brings its services and dumps them at the feet of the Native American Indian, but does not care whether they are accepted, acceptable or reasonable. The Bureau of Indian Affairs and the IHS have brought many programs to the reservations that have not been accepted. Many programs, like the boarding schools, were forced on the Native American Indian, and acceptance was not sought. Federal programs are often mistrusted by tribal groups. History is well remembered by the Native American Indians.

An epidemiological approach to HIV/AIDS education on the reservations was a conference labeled "Groundswell." The targeted group was the traditional healers. Because of the traditional ceremony of the Sundance and the piercing of the skin, the traditional healers were taught about the spread of AIDS/HIV through the sharing of blood products. With this knowledge, traditional healers can now come to IHS facilities

and receive gloves and disposable scalpels for use in the Sundance.

Another grass-roots type of program is the Healthy Start grant. The tribes within the Aberdeen area IHS boundaries joined together in a proposal to reduce infant mortality by 50 percent in the next five years. The approaches used in the different and various reservations will be grass-root efforts. Each location is to come up with a plan for its individual area which will address the needs and will have an impact on overall infant mortality.

Many Native American Indians are not well informed about their benefits, their health needs, etc., so utilization of the local radio stations to broadcast events, council meetings, health-related events and topics is important.

At the grass-roots level in South Dakota is Senator Daschle. He is an advocate of the people of the state—all the people. Senator Daschle includes the Native American Indian residents when he considers his constituents. Senator Daschle has been a strong force in Congress in addressing the needs of Native American Indians.

Many grass-roots issues are lost within the silent majority. There is a tribal council made up of representatives from all the reservation communities. The councils have set agendas, and there is a mechanism built in to stop certain issues. The issue on the reservation deals also with control. Although the Native American Indians are counted for population, they are often neglected in receiving fiscal support from the state. Many Rosebud Sioux Indians are more concerned about who has jurisdiction over the highways on the reservations than about the problems of alcoholism, FAS rates, infant mortality, etc.

There are radical groups that are also grass roots. These groups involve the complainers and/or activists. These people effect change in a very public and sometimes violent way. Because their actions are too radical, the overall effect is negative and brings negative impact to Indian people. An example is the budgetary distribution system within the Indian Health Service. When IHS reviewed their distribution system, they used many factors to evaluate the needed distribution of fiscal funds. It was found that some areas were receiving 125 percent of their needed base, while areas such as the Aberdeen area was receiving from 65-80 percent of its needed funding. Could this disparity come from the Wounded Knee incident of 1972–73? Just maybe. This disparity cannot be changed, because those tribes with overfunding have already established programs based on the funding levels, and to reduce these levels would impact on the level of care provided. Still, the Aberdeen area struggles to provide the needed level of care with minimal and insufficient funding.

The sixth method is to expand and diversify: to include established responsible groups—women's groups, minority groups, senior citizen groups, health groups and to include more "radical" groups—increase the respectability of your group.

There is a problem with ties to other groups. This could affect the sovereignty of the tribes. In order to receive funding from state governments, the tribes must sign statements allowing the state to audit their records and retrieve funds if programs are mismanaged. The uniqueness of the tribes and their sovereignty is threatened. They are no longer unique entities, but can be owned or governed by the states.

Radical groups such as the American Indian Movement, or AIM, have brought awareness to the plight of the American Indian, but their violence has portrayed Indians as savages and unable to adapt to living, as expected, in this great melting pot.

The last method is the support and

pressure of public agencies: you're the client, you're strongly affected by agency actions; help them understand. To prove a point, our public agency, the South Dakota Department of Health, is not present at this meeting set up by Region VIII. PHS Regional offices give technical support to the states. There are nine reservations within the boundaries of South Dakota. The poorest county in the entire United States is Shannon County, which houses the Oglala Sioux Indians (Pine Ridge). The fourth poorest county in the entire United States is Todd County, which houses the Rosebud Sioux Indian Tribe. Because the federal government provides BIA and IHS support to these tribal groups and reservations, the state does not provide support.

An example of the support needed would be public health nurses. Counties request PHNs but Shannon, Todd, and other counties which house reservations do not have state PHNs. There are IHS PHNS, but there are many people within the state boundary who fall through the cracks. They are not eligible for IHS health care and there is no other service available to them. They are citizens of the State of South Dakota and do not receive care because of the policy pertaining to Native American Indians.

I asked Bertha Gipp, a registered nurse from North Dakota, "What shall we do?" She recommended that we teach the tribal governments covered by Indian Heath Service. In this way the Indian members can understand the process so that the position and power does not affect them, but so that they will understand their responsibility.

Indian culture and tradition do not include alcoholism, child, spousal, elderly or sexual abuse or neglect. The problem is one of denial. Since these elements are not part of our historical perspective, it is hard to identify—and treat—the problem. Like language, we may not have a word for something simply because it was not part of our culture.

National Health Care Policy: Are We Treating the Causes or the Symptoms?

The Reverend Marjorie B. Lewis, Ph.D.

Alternative Perspectives on Health Care Motivation

Issues associated with the impact of public policy on American women of African descent include a significant component which addresses health policy.[1] Among these issues is the tension between what the minority community of interest (African American women) perceives to be important health issues, verses those of the dominant community of interest (health care givers, administrators, and analysts). [2]

Purpose

This research does not feature a theoretical treatise on health care policy. Instead, it applies a process, incorporating the perspectives of Rapoport (1965), Kuhn (1962), Lindblom and Cohen (1979), and Redford (1969). These policy theorists influence the direction and issues associated with this work in the following ways. Anatol Rapoport, for example, in his work *Operational Philosophy: Integrating Knowledge and Action*, points out the importance of praxis, research-based empirical exercises with action-oriented implications.[3] Thomas S. Kuhn, in his work *The Structure of Scientific Revolutions*, provides a basis for methodically introducing precursors to paradigm shifts, particularly in relation to public policy formulation and implementation. Emmette S. Redford, in his work *Democracy in the Administrative State*, provides a rationale for defining, comparing and contrasting policy issues at the micro and macro levels, respectively. Each of these theoretical orientations is included in this research. There are two purposes of this research. The first is to identify the differences between perspectives of the minority and the dominant community on personal and national health policy priorities, respectively. The second is to provide insights into health policy reform as a function of paradigm shifts within non-geographically constrained minority communities.

Hypothesis

The hypothesis is based on a preliminary tally of opinions of ten American women of African descent.[4] Their opinions regarding variances between the priorities of national health care policy and their own priorities are stated in the following hypothesis.[5] **There are significant differences between the priorities of national health care policy and the health care priorities of minority communities.**[6] In this case the minority community is a non-geographically constrained cohort of American women of African descent.

Method

Data in this study comes from a controlled questionnaire survey of American women of African descent within the Denver Metropolitan area. Their responses regarding health care concerns are compared and contrasted with national concerns identified at a national health care conference.

As was the case with the hypothesis, the items on the questionnaire were developed from the same "pre-questionnaire" respon-

dents. Using their opinions, the questionnaire was designed and distributed to 200 representatives of various cultural classes within the community of American women of African descent.

The questionnaire was distributed and collected between May 15, and June 15, 1992. There has been a 65 percent response rate (130 persons) to date.

The responses to the questionnaire are currently being used for three purposes. First, the questionnaire is being refined for increased circulation. We are hoping to increase our sample of this community (American women of African descent) both within Denver and nationally in order to enrich our analysis. Second, the responses to the questionnaire are being used to provide insights into more comprehensive health care reform. We hope to add insights into proposing strategies to accommodate both individual and collective implications of health policy concerns. Third, the responses are used to offer another approach to framing communities of interest. We propose to identify them outside of spatial parameters. An ANOVA (Analysis of Variance) was used to interpret the descriptive data. The software program employed was SAS.

Rationalizing the Usage of the Cohort Surveyed

Let us consider a contemporary approach to policy reform: community-based empowerment. For purposes of this research we will define community-based empowerment as a diffusion process used to transform "at-risk" communities into those which manifest fewer anti-social or self-destructive characteristics. Theoretically, the catalysts for change in community-based empowerment would be all members of the minority community (prospective community of change). However, there is also a self-actualization process that must occur in order for all potential members of said community to participate as catalysts of change. From an empirical perspective, there are some members who, given time and money constraints, would not participate as catalysts for change.

It is important, when one considers the process of community-based empowerment as reform, to identify the attitudes of those who will be the innovators (as measured by some indicator of a high propensity to participate in community-based activities). We used a controlled survey to represent the perspectives of a cross section of American women of African descent within the Denver Metropolitan area.[7] Participants for this research were sampled from groups with demonstrated high propensities to invoke change early during the diffusion process. The participants included (1) mothers of gang members, (2) members of the Delta Sigma Theta Sorority, Inc., and (3) African American female members of the East Denver Ministerial Alliance.[8]

Discussion of Findings

The results of the questionnaire provide information within the following categories: (1) a profile of the respondents, (2) respondents' personal health care needs, (3) a comparison and/or contrast between their perspectives of traditional health care policy priorities and national health policy, and (4) a summary of health care policy reform issues proposed by the respondents to the questionnaire. A profile of the respondents was used to identify linkages between the types of respondents (their ages, economic status, and personal health care habits) and the health care issues they identify. Their perspectives on health policy are included to identify insights into and/or tensions between presuppositions of traditional health representatives (care givers,

administrators, and analysts) and the perceived needs for health care by American women of African descent. These tensions yield insights into comprehensive preventive health maintenance.

Profile of Respondents

The profile of the respondents includes a summary of their demographic background, their nutritional and exercise habits, their interaction with physicians, and a recording of their known illness and operations. Each of these categories is discussed in this section, featuring the percentages of respondents who identified with the various alternatives provided in each category. As will be shown, these women represent a variety of economic levels and social interests. In the area of racial ethnicity and propensity to participate in community-based reform, these women are homogeneous (possess the following similar qualities) in that they have attended at least three community-based workshops, rallies, etc., and they are all American women of African descent. The attitudes of these women incorporate those ranging from teenager to senior citizen. The age range of the respondents was from 16 to 66. The attitudes of persons approaching middle-age seem to dominate. The mean (arithmetic average) age of the respondents is 32 years. The median (the majority) age of the respondents was 37 years. The mode (the actual mid-point) of the ages was 42.

Female-headed households outranked dual-headed households for this sample by 20 percent. Forty-four percent of the respondents were married and fifty-six percent of the respondents were not.

The annual family income of the respondents is categorized into three areas: (1) those married, (2) those not married, and (3) combined.

As would be expected, the range of family incomes of persons who reside in dual-headed households was greater than those of single-headed households. For those respondents who are married the income levels ranged from $14,000 to $162,000 annually. For those respondents who are not married, the income levels ranged from $9,200 to $82,000 annually. However, there was much more disparity among the single-headed household incomes than among both the dual-headed categories. The mean income was $65,000, $41,000, $51,000 for respondents who are married, not married and the groups combined, respectively.

More than half of the women in the single-headed household category made $33,000 or more annually. While 17 percent of the women in this single category made less than $13,000 annually, 17 percent of the women also made greater than $53,000 annually. Five percent of the women in this category made more than $73,000 annually. Thus it appears that single women in this survey had a higher probability of earning extremely high or extremely low household incomes. Additionally, the greater number of women in this survey made $35,000 per year, which indicates that for a majority of the single-headed household women, the salaries would be considered moderate. The median incomes were $72,000, $33,000, and $42,000 for respondents who are married, not married, and the groups combined, respectively.

The model incomes were $70,000, $35,000, and $48,000 for respondents who are married, not married, and the groups combined, respectively.

Most of the households included no more than two children. Less than three percent of this group had more than four, and six percent of this group had no children. Most of the women had two children. The number of children residing in the home

ranged from none to six. The mean, median, and mode for this category were four, two, and two, respectively.

The women in the group surveyed were relatively highly educated. More than half of the women surveyed had attained at least three years of post-secondary education. All had acquired a high school diploma. The educational level of the respondents ranged from high school graduate to Ph.D. certification. The mean, median, and mode for this category were 18 years, 16 years, and 15 years, respectively.

In relation to vocations, a general breakdown provided the following: twenty-four percent of the respondents were not gainfully employed; thirty-two percent of the respondents were non-professional; the remaining forty-four percent of the respondents were considered professional.[9]

Eighty-nine percent of the respondents had access to some type of health insurance or care. The remaining eleven percent did not.[10]

Health Maintenance/Nutritional Habits

Health maintenance and nutritional habits included exercising habits, routine visits to the physician, and information regarding types of illness and recommended operations.

In relation to fruit and vegetable intake, forty-seven percent of the respondents ingested a substantial portion (three to four servings) of fruits and or vegetables on a daily basis. Thirty percent ingested a moderate portion (two servings) of fruits and vegetables and the remaining twenty-three percent ingested a minimal portion of fruits and vegetables daily.

Water intake also varied. Seventeen percent drank eight glasses, 38 percent drank from five to seven glasses, 22 percent drank three to five glasses, 14 percent drank one to two, and the remaining nine percent drank less than one glass of water daily.

Other liquid intake responses regarding habits yielded the following. Sixty-nine percent of the respondents ingested at least one glass of milk and/or juice daily. Fifty-seven percent of the respondents ingested at least one cup of coffee daily.

Regarding cigarette smoke intake, thirty-two percent of the respondents smoke at least one cigarette daily. Twenty-seven percent smoke at least three cigarettes daily. Seventeen percent smoke at least seven cigarettes daily. Ten percent of the respondents smoke at least 10 cigarettes daily.

Health Maintenance/Exercise

Questions were also posed to the respondents regarding their exercise routines. Sixty-two percent of the respondents exercised (walk, trips to the spa, calisthenics, sports, etc.) at least once a week. Forty-nine percent of the respondents exercised at least three times a week. The exercise routines ranged from ten minutes to one hour and fifteen minutes daily.

Generally, the women in this survey participated in healthy activities with the exception of regular visits to the physician. Only fifty percent of the respondents made routine visits to the physician without being ill. Only 32 percent of the respondents made routine visits to the dentist without being motivated by a tooth ailment.

Prevalent Diseases

The most prevalent disease among the respondents was high blood pressure. Forty-seven percent of the respondents suffered from this disease. The range of ages was from 18 to 66 years. The mean, median, and modal ages for this disease were 37, 35, and 33. The second most prevalent disease among the

respondents was the existence of fibroid cysts. Thirty-eight percent of the respondents have experienced this disease. The range of ages of women affected by this disease was 24 through 62 years. The mean, median, and modal ages for this disease were 34, 39, and 42, respectively.

The third most prevalent disease among the respondents was migraine headaches. Twenty-nine percent of the respondents experienced this disease. The range of ages of women affected by this disease was 18 to 65. The mean, median, and modal ages for this disease were 33, 36, and 35.

The National Health Care Concerns

The national health status issues are identified at the federal level to include five categories. They are substance abuse, mental health, reproductive health, violence, and chronic disease.

Substance abuse includes chemicals, alcohol, and drugs (prescribed or illicit). The implications of said abuse include violence against women, chronic illness, poor pregnancy outcomes, the transmission of HIV/AIDS, and unnecessary death.

Mental health generally addresses issues associated with depression. This depression has been identified as resulting from racism, lower educational and income levels, low-status/high-stress employment, immigration and acculturation, larger family sizes, marital dissolution, single parenthood, and poor health. Reproductive disorders are also identified as a national health priority. These issues address the reproductive process beginning with menstruation, particularly amenorrhea, dysmenorrhea, PMS, and iron deficiency anemia. Further along the reproductive process other disorders would be identified. The major disorder would be sexually transmitted diseases (STD), which are reported to affect women more severely than men. These diseases include syphilis, gonorrhea, chlamydia trachomatis infections, genital herpes, human papillomavirus, chancroid, hepatitis B, vaginitis, and the human immunodeficiency virus (HIV). The implications of these diseases include infertility, sterility, ectopic pregnancies, blindness, cancer, fetal and infant deaths, birth defects and mental retardation.

Violence in relation to national health policy concerns may be categorized into additional areas including family violence (child, adolescent, and abuse), rape and sexual assault, and elder abuse. As with the other priorities, there is a higher rate of this type of violence among population cohorts of color.

Finally we have the chronic disease category. The major diseases include heart disease and strokes, and mortality due to breast cancer, cervical cancer, and lung, colorectal, and stomach cancer.

Respondents Identification of Perceived Traditional Health Care Policy Issues

The women were asked to list five factors they perceived to be the concerns of the general public, including the health care facilitators. These concerns were identified as concerns that were outside of their community of interest.[11] Their responses were numerous. The five most prevalent perceived areas of external concern to our community of interest included (1) AIDS, (2) other sexually transmitted disease, (3) poor pre-natal care for teenage mothers, (4) drug abuse users and their offspring, and (5) infant mortality. Of the 130 respondents, 102 (79 percent) believed that the external community was concerned about the issue of AIDS within their local community.[12] However, in the pre-survey workshop with the 10 representatives for this sample, there was minimum concern regarding the probability of contracting AIDS,

not to mention its effect on children.

The second most popular perceived external concern was sexually transmitted disease. Ninety-four (72 percent) of the respondents perceived the category to be a prevalent health concern of the outer community.

This category is followed by a perceived concern regarding the quality of pre-natal care of teenage mothers. Eighty-two (63 percent) of the respondents identified this as a concern of persons regulating the health industry, or outside of their community.

Drug abuse was fourth as a category of perceived concern. Eighty-one (62 percent) of the respondents identified this category as an area of concern by outsiders, in relation to their community. Probability of infant mortality was the final choice of the respondents. Sixty-four (49 percent) of the respondents identified this as a category of perceived concern by the care givers and regulators.

Respondents Perspectives on Health Policy

The perspectives of the respondents section includes a summary of both endogenous and exogenous sources of prevalent health issues and their implications. The findings also feature approaches to addressing these health care issues.

Prevalent Health Issues

There were two categories of health issues which were ranked by the respondents in terms of their impact on available health care. The categories were endogenous, stemming from variables perceived as associated within the household (personal), and exogenous, those categories stemming from variables perceived to be imposed from outside of the household (environment).

Endogenous: Items included in the endogenous category were money availability, insurance availability, adequate food, lack of proper housing, and lack of proper transportation. The respondents ranked these categories as follows from most important to least important: (1) lack of adequate insurance; (2) lack of availability of money; (3) lack of proper transportation; (4) lack of availability of adequate food; (5) lack of proper housing; and (6) other.[13]

Exogenous: Items included in the exogenous category were weather conditions, physical safety in the community, sense of well-being in the community, frustration due to racism, sexism, and classism. The respondents ranked these categories as follows from most important to least important: (1) frustration due to racism, sexism, and/or classism; (2) lack of preventive health care instruction; (3) lack of sense of well-being within the community; (4) lack of physical safety within the community; (5) environmental conditions (air, noise, water) ; (6) poor weather conditions; and (7) other.[14]

Within the category of preventive health care instruction were the rankings: (1) prenatal care; (2) post-natal care; (3) proper nutrition; (4) sex education; (5) stress management; (6) the importance of exercise; (7) lack of options for disease treatment; (8) lack of adequate immunizations; (9) personal hygiene, and (10) other.[15]

Approaches to Addressing Health Care Issues

There were six different approaches identified to accommodate the needs of the community of interest within the questionnaire. The categories include (1) universal health care; (2) community-based equity of distribution of negative environmental externalities; (3) community and police partner-

ships for resident safety; (4) cultural competence workshops; (5) community and health care-giver partnerships for health maintenance; and (6) community and health care-giver partnerships for preventive health maintenance. In addition to the six identifiable categories, a seventh, other, category is provided for any additional input to be received from the respondents. The responses of those surveyed are as follows:

(1) Universal health care: Eighty percent of the respondents strongly supported universal health care, ten percent mildly supported, and ten percent felt it was not important.

(2) Equity of distribution of negative environmental externalities among all communities: Twenty percent strongly supported this approach. Thirty percent mildly supported this approach. Fifty percent feel that it is unimportant.

(3) Community and police partnerships to enhance levels of safety in local communities: Forty-seven percent of the respondents mildly supported this issue. Fifty-three percent felt that this approach was not important.

(4) Exercises in cultural competence enabling persons to address lowered self-esteem due to racial, gender, and cultural oppression: Thirty-four percent of the respondents strongly supported the approach. Forty-two percent mildly supported the approach. Twenty-four percent of the respondents felt that this approach was not important.

(5) Community and health care-giver partnerships designed to provide information correlating between stress levels and disease: Eighty-seven percent of the respondents strongly supported this approach. Ten percent of the respondents mildly supported this approach. Three percent of the respondents felt that this approach was not important.

(6) Community and health care-giver partnerships designed to provide information regarding the importance of preventive health maintenance: One hundred of the respondents strongly supported this approach.

(7) Other: Only two respondents added another approach in the other category. The first suggestion was to reform the value structures of our community of interest, as well as the external community. The second suggestion was to involve the churches in the planning of health care reform.

7

Notes

[1] In relation to the term American Woman of African descent, the term is used in order to identify both the nation of origin and the cultural orientation of the community of interest featured in this paper

[2] The term "community of interest," for purposes of this research is defined as a group of persons without a particularly prescribed geographical constraint. Instead, the parameters include national, racial, general, and social action orientations.

[3] *Praxis* refers to the combination of theory and practice. It works by incorporating both stages of the research process. In my opinion this is more representative of the scientific process than either of the stages exclusive of the other.

[4] These women represent the three groups of women surveyed. Four were Deltas, four mothers of gang members, and two were ministers.

[5] Prior to the development of the questionnaire, ten women were interviewed in order to identify relevant health care policy issues and reform strategies, along with ideas regarding perceptions of said women about perceived traditional health care policy issues.

[6] The national health policy priorities used in this research were identified and discussed during the Women of Color Health Conference, held in Denver, Colorado, June 19-20, 1992.

[7] Although the Denver Metropolitan area represents one city, the types of women surveyed are found in every city in this country.

[8] The Delta Sigma Theta Sorority, Inc., is a Christian-based organization comprised of professional women. One may join this organization as an undergraduate or the graduate chapters (city wide). Prominent women such as Mary McLeod Bethune, Shirley Chisolm, Barbara Jordan, and Wilma Webb all belong to this sorority. The mothers of gang members interviewed are also community activists. These mothers are coalescing to address their problems. The female ministers are African-American clergy from the AME, Baptist, and Episcopal denominations.

[9] There was not significant correlation between income and vocational classification.

[10] Of the group that identified access to some type of health insurance, more than 50% of this group felt that the insurance they had was not adequate.

[11] External concerns are those concerns outside of the community of interest. In this case, external concerns are those of national and local care facilitators and policy makers. Community of interest concerns are those of American women of African descent and their families.

[12] At least 132 of the respondents listed AIDS as one of the five items they perceived to be important to the general public in relation to their plight within their community.

[13] Although a sub-sample of respondents was interviewed prior to developing the questionnaire, we included the category "other" to capture any additional opinions that might be mapped to perceived concerns of identified national concerns. Additionally, less than 10% of the respondents were in agreement with any of the items offered within this "other" category.

[14] Ibid.

[15] Ibid.

References

Kuhn, Thomas, S. *The Structure of Scientific Revolutions.* Chicago, IL: University of Chicago Press, 1969.

Lindbloom, Charles, E., and David K. Cohen. *Usable Knowledge: Social Science and Social Problem Solving.* New Haven, CT: Yale University Press, 1979.

Rapoport, Anatol. *Operational Philosophy: Integrating Knowledge and Action.* New York: John Wiley and Sons, Inc., 1965.

Redford, Emmette S. *Democracy in the Administrative State.* New York: Oxford University Press, 1969.

Opening Ceremonies

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Substance Abuse & Minority Women

Violence & Minority Women

Reproductive Health & Minority Women

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State Recommendations

Colorado

The state of Colorado met during the Forum and agreed that the establishment of some kind of minority presence in the state would provide the best mechanism to begin addressing some of the problems experienced by minority women in Colorado. The specific recommendations were as follows:

Recommendation: Minority health coordinators in the regional office of the Public Health Service will be invited to meet with the Colorado attendees and begin discussions on the establishment of an office of minority health in Colorado.

Recommendation: Chris Herrera and Monyett Ellington have been charged with the task of organizing the meeting of attendees and the Public Health Service staff.

Montana

The Montana delegation to the Forum met and developed four recommendations which they will take back for action.

Recommendation: The participants in the Forum will meet again in August in conjunction with the Salish Kootnai College Women's Wellness conference. They will give a presentation and present the plan from the Forum.

Recommendation: A needs assessment tool will be developed in order to determine what the needs of health providers are for cultural competency training. Due to the rurality of Montana, several cultural competency training sessions will then be held throughout the state.

Recommendation: A resource guide for minority women in the state will be developed and published in Spanish, American

Indian and several Asian languages. Efforts will be made to identify other ethnic groups in the state (e.g., Mennonites, Hutterites, etc.) and to identify the various resources which are available in the local community. The guide will include resources for all five tracks targeted at the Forum.

Recommendation: The Women's Lobby Forum in Montana will be contacted in order to inform them of the health needs of minority women and to seek their assistance in getting minority women to vote.

South Dakota

The representatives from the state of South Dakota had two major recommendations. In their deliberations, they felt that there was a need for the South Dakota Department of Health to share its federal resources more fully with the people of color in the state.

Recommendation: The Region VIII Public Health Service should intercede with the State Department of Health on behalf of the people of color in South Dakota to ensure that federal resources are equitably available to all residents of the state of South Dakota.

Secondly, the representatives agreed that they want as many organizations as possible in the state to be aware of the concerns expressed during the Forum. They particularly want women of color to begin to take care of themselves first.

Recommendation: The representatives to the Forum from South Dakota will share the Forum proceedings and recommendations with as many organizations as possible, including

- South Dakota Women's Advocacy Coalition
- South Dakota Medical Society
- Nursing organizations
- Health administrators organizations
- Tribal organizations
- Health organizations
- Females in the Indian Health Service
- Universities

North Dakota

The North Dakota delegation to the Forum established a goal for the year and developed recommendations which were time-phased. The Year I goal for 1992-93 is

> **To establish a North Dakota statewide minority women's Forum to be held in 1993.**

Recommendations—June 1992

1. The delegation will share the proceedings of the Forum at the 22nd annual national conference of the North American Indian Women's Association (NAIWA) which will be held in Bismarck, North Dakota, June 24–27, 1992.

2. A committee will be established to seek funding for a statewide meeting.

Recommendation—July and August 1992

3. The committee will meet during these months to draft an operational plan, including the identification of grant writers and of sources of funding.

Recommendations—September and October 1992

4. A statewide organizational meeting will be called at which the Region VIII Forum's proceedings will be used as a model for developing a statewide action agenda.

5. The delegation will approach the North Dakota Indian Affairs Commission (Governor, four tribal chairs and four at-large members) and seek their approval to request North Dakota emergency funding. Planning will then begin for the 1993 North Dakota Minority Women's Health Forum.

The health needs and issues of ALL women will be identified and a distinction made between those that are all women's issues and those that are minority women's issues.

Funding will be sought for a part-time FTE and a coordinator for the North Dakota Minority Women's Health Forum.

6. The delegation will meet with gubernatorial candidates.

Recommendation—November and December 1992

7. The State Department of Health will be requested to collect data from all sources in order to develop an all-inclusive profile of the health status of North Dakota minority women. This will be compared to the health status of other women.

Recommendation—January to March 1993

8. The focus will be on the State Legislature.

Recommendations—April and May 1993

9. The North Dakota Minority Women's Health Forum will be held.

10. A report and the findings and proceedings of the North Dakota Minority Women's Health Forum will be submitted to the Region VIII Public Health Service.

Utah

The participants from Utah met at the Forum and developed seven recommendations for action and implementation.

Recommendation: Utah will establish teams which will conduct cultural competency training throughout the state.

Recommendation: The State will network with other states in Region VIII in order to identify models which are successful.

Recommendation: Participants will work to establish networks among existing agencies in the state.

Recommendation: Utah delegates will develop mechanisms whereby minorities can have increased access to public policy-making.

Recommendation: A citizen task force will be established to review compliance with existing regulations and policies which mandate equal access for minorities.

Recommendation: Research candidates who are ethnic minorities will be aggressively recruited to collect data from ethnic communities.

Recommendation: A statewide ethnic women's health coalition will be established in Utah.

Wyoming

Following are eight recommendations developed by the six representatives from the state of Wyoming.

Recommendation: The Wyoming participants in the Forum will continue networking together and will hold another meeting (perhaps a conference call) within the next few months.

Recommendation: Participants will summarize the proceedings from the Forum and the Wyoming state plan and present these to the Governor's wife (who served on the Forum Planning Committee), the director of the Wyoming Department of Health and to the Legislative Health Care Committee, and share them with other contacts.

Recommendation: A variety of publicity mechanisms will be utilized in order to increase awareness of the health issues of minority women.

Recommendation: If funding can be obtained, a statewide conference on women's health will be held with a focus on minority women's health issues. If the conference is not possible, an alternative will be the development of a training team/program which would take cultural sensitivity/skills training "on the road."

Recommendation: Participants will work to begin formation of women's advocacy groups at local and community levels.

Recommendation: Wyoming representatives will facilitate the initiation of partnerships with other private and public groups at both the local and state levels.

Recommendation: Women will be encouraged to actively support plans for correcting health provider shortages in Wyoming.

Recommendation: An assessment of the health care needs of minority women in Wyoming will be conducted, and then networks will be established with other states and national offices in order to identify successful strategies for meeting those needs.

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Violence & Minority Women

Reproductive Health & Minority Women

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